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IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-1852

BLUE CROSS OF NORTHWEST OHIO, *Petitioner,*

v.

HARRY V. JUMP, *Respondent.*

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF OHIO

JAMES P. KENNEDY, ESQ.
Vorys, Sater, Seymour and Pease
52 East Gay Street
P. O. Box 1008
Columbus, Ohio 43216

Counsel for Petitioner

Of Counsel:

DAVID S. CUPPS, ESQ.
MICHAEL J. CANTER, ESQ.
Vorys, Sater, Seymour and Pease
52 East Gay Street
P. O. Box 1008
Columbus, Ohio 43216

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BLUE CROSS OF NORTHWEST OHIO, *Petitioner,*

v.

HARRY V. JUMP, *Respondent.*

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF OHIO

Petitioner Blue Cross of Northwest Ohio ("Blue Cross") prays that a writ of certiorari issue to review the final judgment which was entered in this action by the Supreme Court of Ohio on February 20, 1980. In entering that judgment, the Supreme Court of Ohio held that Ohio Revised Code § 1739.051—a state regulatory statute administered by respondent (the "Superintendent") and challenged by Blue Cross—and Insurance Rule 3901-1-28—an administrative rule promulgated by the Superintendent pursuant to the challenged statute—did not infringe Blue Cross's rights under the Fourteenth Amendment to the Constitution of the United States.

OPINIONS BELOW

The text of the challenged statute, the text of the rule and the opinion of the Supreme Court of Ohio holding, 5-2, that the statute and rule are constitutional appear in the Appendix to this Petition. (A. 73a, 78a, and 1a, respectively) In addition, the opinion of the Supreme Court of Ohio is reported at 61 Ohio St. 2d 246, 400 N.E.2d 892 (1980).

The unpublished opinion of the Court of Appeals of Franklin County, Ohio—which unanimously held the challenged statute and rule to be unconstitutional—is set out in the Appendix. (A. 11a-18a) The unpublished opinion of the Court of Common Pleas of Franklin County, Ohio, which decided the controversy between Blue Cross and the Superintendent without reaching the constitutional questions raised by Blue Cross, is set out in the Appendix (A. 19a-31a), as are the unreported decision of the Superintendent (A. 32a-44a) and the unreported recommendation (A. 45a-72a) of the Superintendent's Hearing Officer, before whom this controversy commenced.

JURISDICTION

The judgment of the Supreme Court of Ohio was entered on February 20, 1980. Blue Cross has caused this Petition to be filed in this Court on May 20, 1980, within 90 days after entry of judgment by the Supreme Court of Ohio.

The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1257(3).

QUESTIONS PRESENTED

I. Whether the Ohio statute governing ratemaking proceedings of hospital service associations, which facially requires "a conscientious, vigorous, and continuing attempt by a hospital service association through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage member health care facilities to control costs" is impermissibly vague in violation of constitutional rights guaranteed petitioner by Amendment XIV to the United States Constitution.

II. Whether the Ohio statute governing ratemaking proceedings of hospital service associations was rendered unconstitutional as applied by an unforeseeable and retroactive judicial construction by the Supreme Court of Ohio in *Blue Cross of Northwest Ohio* v. *Jump,* 61 Ohio St. 2d 246, 400 N.E.2d 892 (1980).

III. Whether the Ohio statute governing ratemaking proceedings of hospital service associations, both facially and as construed by the Supreme Court of Ohio in *Blue Cross of Northwest Ohio* v. *Jump,* 61 Ohio St. 2d 246, 400 N.E. 2d 892 (1980), violates constitutional rights guaranteed petitioner by Amendment XIV to the United States Constitution because the state administrative agency which applies the statute is given limitless power, ungoverned by any standards, to disapprove any portion or all of an association's financially-justified rates.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Fourteenth Amendment, United States Constitution:

> Section 1. . . . nor shall any State deprive any person of life, liberty, or property without due process of law. . . .

Section 1739.01, Ohio Revised Code:

In sections 1739.01 to 1739.15 of the Revised Code:

. . .

(L) "Lawful, fair and reasonable" contract, amendment, formula, or rate means a contract, amendment, formula, or rate that is in accordance with sound actuarial principles and reflects a good faith effort by a hospital service association to control costs, including both its own administrative costs and costs charged to it by health care facilities, including hospitals.

(M) "Good faith effort" means a conscientious, vigorous, and continuing attempt by a hospital service association through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage member health care facilities to control costs by accomplishing the following objectives:

(1) Elimination of duplicative or unnecessary services and facilities;

(2) Nonprovider participation in plan affairs;

(3) Subscriber support of cost containment activities;

(4) Promotion of sound management practices in member health care facilities;

(5) Implementation of sound plan management practices;

(6) Promotion of alternative forms of care;

(7) Engagement in, and evaluation of, cost control experiments, including incentive reimbursement and utilization review programs;

(8) Adoption of other cost containment policies as determined by the superintendent of insurance.

Section 1739.051, Ohio Revised Code:

If any hospital service association desires to:

(A) Enter into or amend any contractual relationship with any hospital, skilled nursing facility, home health agency, community mental health and retardation board, mental health service facility, or ambulatory health facility;

(B) Issue or amend any subscriber contract for such services;

(C) Establish or change any group rating experience formula used in determining a group rate charged for a group subscriber contract;

(D) Establish or change any rate charged for any subscriber contract, other than a group rate for group subscriber contracts determined in accordance with a group rating experience formula which has been approved by the superintendent of insurance. A copy of the proposed contract, amendment, formula, or rate shall be filed with the superintendent of insurance and shall not be effective until the expiration of ninety days after the filing thereof unless he shall sooner give to such association his written approval thereto. If the superintendent is not satisfied within such ninety-day period, that every portion of any such contract, amendment, formula, or rate is lawful, fair, and reasonable, he shall either so notify such association and it shall thereafter be unlawful for such association to use any such contract, amendment, formula, or rate, or that portion or portions of the contract, amendment, formula, or rate which he finds to be unlawful, unfair, or unreasonable, or he shall set a date and time for a public hearing to commence no later than ninety days after receipt of said filing. The superintendent shall give public notice of any such hearing. He may also hold public hearings for hospital service as-

sociations to determine compliance with sections 1739.01 to 1739.16 of the Revised Code and rules promulgated thereunder. Such public hearing may include consideration of a proposed contract, amendment, formula, or rate, or may be called by the superintendent with sixty days' written notice to the hospital service association solely to determine the compliance of that association with Chapter 1739. of the Revised Code and rules promulgated thereunder. The superintendent shall develop rules and reporting requirements to indicate activities necessary to establish a good faith effort to control costs. At every public hearing, a hospital service association must show by reliable, probative, and substantial evidence that the association is exerting a good faith effort to control costs. He may also require the association to give public notice of such hearing.

The superintendent may retain at the association's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the superintendent's staff as shall be reasonably necessary to assist in the conduct of any public hearing under this section. Such expenses shall not exceed an amount equal to one one-hundreth of one per cent of the sum of premiums earned plus net realized investment gain or loss of such association as reflected in the most current annual statement on file with the superintendent. Any person retained shall be under the direction and control of the superintendent and shall act in a purely advisory capacity. The superintendent shall, within thirty days after the commencement of a hearing issue an order approving any proposed contract, amendment, formula, or rate if he finds it to be lawful, fair, and reasonable, or approving only that portion of a proposed contract, amendment, formula, or rate which he finds to be lawful, fair, and reasonable, or disapproving any proposed contract, amendment, formula, or rate if he

finds it otherwise, or withdrawing his approval of any existing contract, amendment, formula, rate, or any portion thereof on any of the grounds stated in this section. Any action by the superintendent following a public hearing shall be effected by written order which shall state the grounds for disapproval.

Any action taken or order issued by the superintendent pursuant to this section may be appealed by the association as provided for in section 119.12 of the Revised Code.

STATEMENT OF THE CASE

Preliminary Statement

In 1972 the Superintendent's agency denied a rate increase requested by Blue Cross on the stated ground that Blue Cross "failed to exert any effective influence on its member hospitals to operate more efficiently." At that time there was no statute or rule authorizing the agency to take a hospital service association's cost containment efforts into account in a ratemaking proceeding: Therefore, the agency's attempt to create by adjudication authority which the legislature had not given it was promptly disapproved by the courts of Ohio. *In re Blue Cross,* 40 Ohio App. 2d 285, 319 N.E. 2d 212 (Ct. App. 1973); see also *In re Blue Cross,* 44 Ohio App. 2d 375, 338 N.E.2d 775 (Ct. App. 1974), *aff'd,* 44 Ohio St. 2d 78, 337 N.E.2d 783 (1975); *In re Blue Cross,* 34 Ohio Misc. 29, 296 N.E.2d 305 (Common Pleas 1972).

In 1976 the Superintendent successfully urged the legislature to provide a statutory basis for making an association's attempts to control hospital costs relevant in a ratemaking proceeding. In addition, the Superintendent promulgated Rule 3901-1-28. (A. 78a) That

statute and rule are at the heart of this case for—while both make it clear that the Superintendent *must* take cost-containment efforts into account in a ratemaking proceeding—both are so vague that neither the associations nor the Superintendent nor courts called upon to review the Superintendent's ratemaking orders knows what is operative or how whatever is operative will be taken into account in the Superintendent's decision to grant or deny financially justified rates.

The Statutory Provisions

Where, as in this case, a hospital service association seeks to adjust rates, the challenged statute provides:

> Sec. 1739.051. If any hospital service association desires to: . . .
>
> (D) Establish or change any rate . . . a copy of the proposed . . . rate shall be filed with the superintendent of insurance and shall not be effective until the expiration of ninety days after the filing. . . . If the superintendent is not satisfied within such ninety-day period, that every portion of any such . . . rate is lawful, fair, and reasonable, he shall either so notify such association and it shall thereafter be unlawful for such association to use any such . . . rate, or that portion or portions of the . . . rate which he finds to be unlawful, unfair, or unreasonable, or he shall set a date and time for a public hearing to commence no later than ninety days after receipt of said filing. . . . The superintendent shall, within thirty days after the commencement of a hearing issue an order approving any proposed . . . rate if he finds it to be lawful, fair, and reasonable, or approving only that portion of a proposed . . . rate which he finds to be lawful, fair, and reasonable, or disapproving any proposed . . . rate if he finds it otherwise.

The statute thus contemplates that, after hearing, the Superintendent "shall" approve the rate, or the portion of the rate, which is lawful, fair, and reasonable and shall disapprove any rate if it is unlawful, unfair and unreasonable. "Lawful, fair and reasonable" are statutory terms:

> "Lawful, fair and reasonable" . . . rate means a . . . rate that is in accordance with sound actuarial principles and reflects *a good faith effort* by a hospital service association *to control costs, including both its own* administrative costs *and costs charged to it by* health care facilities, including *hospitals.*

Ohio Revised Code § 1739.01(L) (emphasis added). In addition, "good faith effort" is a statutory term:

> "Good faith effort" means a conscientious, vigorous, and continuing attempt by a hospital service association through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage member health care facilities to control costs . . . .

Ohio Revised Code § 1739.01(M).

Pursuant to those statutory provisions, on October 14, 1977, Blue Cross filed with the Ohio Department of Insurance an application to adjust rates for non-group subscriber contracts. The gross increase in revenue for which Blue Cross sought authorization was an increase of 35.9 percent over revenue from its existing rates for this class of service.

The Initial Hearing

Pursuant to Section 1739.051, the Department of Insurance conducted a public hearing regarding Blue

Cross's proposed rate adjustments. The hearing before the Hearing Officer, a former Superintendent of Insurance appointed by the Superintendent, commenced on November 29, 1977, and continued for four days, resulting in a transcript of 1349 pages. Blue Cross supported its application with direct testimony, written statements, and numerous exhibits. While Blue Cross's executives and staff were subjected to extensive cross-examination by the Superintendent, the Superintendent introduced no other evidence at the hearing.

The Hearing Officer issued his Report and Recommendation on December 23, 1977. He found that Blue Cross had demonstrated its financial need for the requested rate adjustments. Indeed, the Hearing Officer stated:

> The basic principle of rate making is that the premium charged should produce sufficient funds to pay all expected claims and expenses of the group covered plus a factor for additions to reserves that may be needed for unexpected claims or expenses. . . . The testimony and exhibits demonstrate that [Blue Cross] sustained an underwriting loss on its non-group business of $3,816,283.71 for the period of July, 1976 through June, 1977 . . . . It appears certain that the losses on this class of business will continue and probably will increase because of the continuing increase in the cost of hospital care unless a rate increase is approved. Cross-examination by the Insurance Department did not controvert either the actuarial calculation used or the demonstrated need for the rate increase requested. I therefore find that [Blue Cross] has justified the need for the increase applied for and that their filing is in accordance with sound actuarial principles. (A. 47a)

The Hearing Officer also found that Blue Cross was in compliance with all but three of the applicable cost-containment provisions of Rule 3901-1-28, and was in "partial" compliance with those. (A. 58a, 60a, 67a) The Hearing Officer accordingly recommended that the Superintendent approve an average 25 percent rate increase, rather than the average 35.9 percent increase proposed by Blue Cross.

The Superintendent's Order

The Superintendent agreed with the Hearing Officer that the proposed rates were actuarially sound. (A. 33a) Nevertheless, he concluded that Blue Cross had not complied with four provisions of the rule. He stated, "Ohio's health care consumers are entitled to more progress in the cost containment area than is indicated in the record" and denied the actuarially justified rate increase in its entirety.

Judicial Review In The Court of Common Pleas

Pursuant to Ohio's Administrative Procedure Act, Ohio Revised Code §§ 119.01 *et seq.*, appeals from an agency are heard in the Courts of Common Pleas, Ohio's courts of first instance, and those courts are the final arbiters of factual matters, in that, if an agency's findings are not supported by substantial evidence, those courts may make such ruling as is so supported. See Ohio Revised Code § 119.12. Pursuant to Ohio's Administrative Procedure Act, Blue Cross sought judicial review of the Superintendent's unprecedented order in the Court of Common Pleas of Franklin County, Ohio. That Court found that the evidence of record established that Blue Cross was in compliance with all aspects of Rule 3901-1-28.

Upon consideration of the entire record, that Court found—as the Hearing Officer and the Superintendent had—that Blue Cross had demonstrated financial need for the proposed rate adjustments in accordance with sound actuarial principles. (A. 23a) Moreover, that Court found that Blue Cross had demonstrated by reliable, probative, and substantial evidence its "good faith effort" to control costs, including its own administrative costs and costs charged to it by hospitals. That Court also found that the Superintendent's findings to the contrary lacked the support of reliable, probative, and substantial evidence. That Court therefore vacated the Superintendent's order and ordered that Blue Cross implement a 30% average rate increase.

Judicial Review In The Court of Appeals

On July 10, 1978, the Superintendent appealed from the judgment of the Court of Common Pleas. Blue Cross also appealed in order to preserve its constitutional challenges to the statute and rule in Ohio's appellate courts. The Court of Appeals modified the judgment of the Court of Common Pleas to allow Blue Cross's proposed rates in their entirety and, as so modified, affirmed the judgment.

The Court of Appeals held that the record compiled at the administrative hearing did not support the Superintendent's order. Attempting to construe the challenged statute, the Court of Appeals suggested that the Superintendent must have believed the statute to require *ad hoc* "results" rather than good faith "efforts" and that, in any event, the Superintendent had "retroactively promulgated a standard of performance required of Blue Cross" far beyond any standard rooted in the statute. (A. 13a)

The Court of Appeals—sustaining in part the assignments of error presented by Blue Cross—held that the statute had been unconstitutionally applied by the Superintendent in the case before it, but declined to strike down the entire statute for vagueness on the ground that, in future cases, "one must assume that duly appointed administrators will allow common sense to prevail." (A. 16a) The Court of Appeals could save the statute no further, however. When it reached the apportionment provision of the statute, the Court of Appeals concluded:

> . . . neither the statute nor the rule deals with what, if any, portion of an otherwise justified rate increase may be deducted following a finding of partial compliance with the "good faith" standard. In this area the statutory scheme is not just vague but, rather, standards for adjudication are non-existent.
>
> * * *
>
> Surely, the General Assembly did not mean to grant unbridled discretion in this critical area. But, sad to say, that is precisely the situation at bar. Both the Blue Cross systems and the reviewing courts are confronted with a totally unpredictable and arbitrary morass in the critical area of rate adjustment. (A. 16a-17a)

Judicial Review In The Supreme Court of Ohio

From the Court of Appeals, the Superintendent sought review in the Supreme Court of Ohio. Although two judges of that Court would have declared the statute void for vagueness and its apportionment provisions void for want of standards (A. 9a-10a), the

majority reversed the judgment of the Court of Appeals and held the challenged statute constitutional.

The Supreme Court of Ohio—construing the challenged statute—held that the language "attempt . . . through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage . . . [hospitals] to control costs" instructed Blue Cross to use "primarily" financial incentives and disincentives to induce the hospitals which it pays on behalf of its subscribers to control their costs of service. Then—construing the Superintendent's order—it held that the Superintendent had denied Blue Cross's requested rates because he found that Blue Cross "completely failed" to use such financial incentives and disincentives.[1]

---

[1] With both deference and recognition that this question is not tendered to this Court for review, the Superintendent's order appears to have been premised, not on a finding that Blue Cross "completely failed" to use financial incentives and disincentives, but on the Superintendent's conclusion that Blue Cross's efforts in four of 23 specific areas were not vigorous enough. Thus the Superintendent introduced his discussion by saying, ". . . we feel that [Blue Cross's] *progress* in the cost containment area since the last hearing (February, 1977) is of major importance" (A. 33a; emphasis added) and concluded it by saying, "Ohio's health care consumers are entitled to more *progress* in the cost containment area than is indicated in the record. We must repeat that [Blue Cross's] cost containment efforts must be 'conscientious, continuous and vigorous' . . . ." (A. 44a; emphasis added) Indeed, if the Superintendent had intended to find that Blue Cross "completely failed" to use financial incentives and disincentives, he would surely have dealt with the Hearing Officer's express findings to the contrary [A. 55a (delayed reimbursement); 57a (financial disincentive to hospital expansion); 61a (contractual limitation on bad-debt reimbursement); 68a (incentive reimbursement)] and with the Hearing Officer's statement:

> Counsel for the Insurance Department throughout his entire cross-examination carefully and thoroughly inquired into every hospital or health care facility program, procedure or expenditure to determine if [Blue Cross] had used education, persuasion and financial incentives and disincentives or a combination of them to control costs and to encourage the hospitals and other health care facilities to control costs. The answers to his questions always involved persuasion usually coupled with education or a financial incentive or disincentive. The financial incentives and disincentives were usually the willingness or unwillingness of [Blue Cross] to reimburse the hospital or health care facility for all or a part of the expenditure of the hospital or facility. (A. 69a)

The Supreme Court of Ohio noted that neither the statute nor the rule guides the Superintendent in determining whether to approve substantially all, a modest part, or substantially none of a proposed rate increase where, as in this case, the applicant has been found to have complied with some, but not all, of the *desiderata* of the Superintendent's cost-control rule. Holding that, when Ohio's legislature "delegates power to an administrative official, it must provide standards *insofar as it is possible to do so*" (A. 8a; emphasis added), the Supreme Court of Ohio concluded that the present statute was one where the legislature could not do so. In short, the Supreme Court of Ohio held that it was consistent with due process for the legislature of Ohio to delegate absolute adjudicatory power to an administrative official, unguided by any standards selected by the legislature, and—by necessary hypothesis—unreviewable in the absence of such standards by any court.

REASONS FOR GRANTING THE WRIT

This Petition tenders three questions which merit consideration and decision by this Court. The first question involves fundamental constitutional pronouncements of this Court: It has been suggested that

the void-for-vagueness doctrine operates on two levels —one level which is operative where legislation impacts certain interests in "liberty" and another which is operative where legislation impacts interests in "property." *Papachristou* v. *City of Jacksonville,* 405 U.S. 156; *Ashton* v. *Kentucky,* 384 U.S. 195. While the challenged statute may well fail under any test, this case presents an opportunity, in the course of considering the challenged statute, to consider also whether the void-for-vagueness doctrine is not variable, but rather a neutral principle of constitutional law which applies with the same force whether the litigant invoking it seeks to protect "life, liberty, or property."

The second question is whether the rule in *Bouie* v. *City of Columbia,* 378 U.S. 347—that is, the rule that an unforeseeable and retroactive judicial construction of a statute, which gives the statute a scope not fairly inferable from its language, violates the affected litigant's due process rights—is applicable not simply to penal statutes, but to regulatory statutes of all descriptions. To date this Court has applied the *Bouie* rule only to penal statutes. However, it is clear that the *Bouie* rule, applied in a penal context, serves only society's interest in limiting governmental power: It does not also serve society's interest in justifying reasonable expectations. Those charged under a penal statute usually are "not alerted to the regulatory schemes . . . and we assume they would have no understanding of their meaning and impact if they read them," *Papachristou* v. *City of Jacksonville,* 405 U.S. 156, 163. Indeed, if such persons read more widely, it would not be "unfair to require that one who deliberately goes perilously close to an area of proscribed

conduct shall take the risk that he may cross the line," *Boyce Motor Lines* v. *United States,* 342 U.S. 337, 340. Thus regulatory statutes are more, not less, appropriate than penal statutes for the *Bouie* test. For regulatory statutes are addressed to a narrow, specific audience motived to understand and, in most cases, to comply with such statutes. Accordingly, in the case of a regulatory statute, like the Ohio statute tendered for review, an unforeseeable and retroactive construction not contemplated by—if permitted by—the language of the statute defeats not only the constitutional values protected by *Bouie,* but the justification of legitimate expectations.

Finally, in this case the Supreme Court of Ohio has held in clearest terms that, in delegating adjudicatory functions to an administrative agency, the state may constitutionally delegate power to decide matters of substantial public importance without establishing standards to govern or guide the adjudication. It seems clear that the due process values implicated by such delegation are rights to notice and fair hearing. This case presents an opportunity to pass on the question whether a state may, in entrusting adjudicatory functions to an officer of the state, give persons whose rights are to be subject to adjudication notice of nothing except the subject matter to be adjudicated. In light of the fact that government by administrative agency has, since the 1930's, become the norm in the United States, the question whether Ohio, or any state, deprives its citizens of due process by such conduct is too important to be denied review.

I.

The Ohio Regulatory Statute Is Impermissibly Vague. Therefore The Decision of The Supreme Court of Ohio in This Case Is Not In Accord With Applicable Decisions of This Court.

The challenged statute requires the Superintendent to approve any "lawful, fair and reasonable" rate. A rate is "lawful, fair and reasonable" if it is actuarially sound—as petitioner's proposed rates concededly are; if it reflects a good faith effort by an association to control its own costs—as petitioner's proposed rates concededly do; and if the association has made a "good faith effort" to control the costs of the hospitals to which it makes payments on behalf of its subscribers.

Yet who can ever know—save by fiat—whether or not Blue Cross has satisfied the challenged statute's final test. For good faith effort means:

> . . . a conscientious, vigorous, and continuing attempt by a hospital service association through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage member health care facilities to control costs . . . .[2]

This statutory definition of "good faith effort" is constitutionally defective. It simply does not contain any objective criteria by which a hospital service association, the Superintendent, or the reviewing courts can determine what degree of effort or quantum of activities is legally sufficient to demonstrate compliance with the law. Judgment as to what constitutes a "conscientious, vigorous and continuing attempt to encourage" is necessarily and entirely subjective, and when such a subjective judgment is at the very foundation of the ratemaking process, then the ratemaking process necessarily becomes subject to the arbitrary and uncontrolled will of the Superintendent.

[2] Rule 3901-1-28 does not further define what is meant by "good faith effort," but merely states that "good faith effort," as used in the rule, shall have the meaning attributed to it in § 1739.01(M).

No hospital service association can determine what specific affirmative acts are required and, if engaged in, would constitute compliance with the statute. Therefore, regardless of the extent of its cost-containment efforts, Blue Cross can never be certain that, in the subjective judgment of the Superintendent after the fact, it will be deemed to have complied with the statute. The observations of this Court regarding an inherently vague regulation apply with equal force to the statutory definition of "good faith effort."

> Observe that the section forbids no specific or definite act. It confines the subject-matter of the investigation which it authorizes [by court and jury after the act] to no element essentially inhering in the transaction as to which it provides. It leaves open, therefore, the widest conceivable inquiry, the scope of which no one can foresee and the result of which no one can foreshadow or adequately guard against.

A. B. Small Co. v. *American Sugar Refining Co.*, 267 U.S. 233, 239.

The inherent vagueness of the "good faith effort" language is graphically illustrated by the totally contradictory conclusions reached by the Hearing Officer, the Superintendent and the trial court in this case. Upon a review of Blue Cross's efforts, the Hearing Officer determined that Blue Cross had satisfied completely or substantially—by what was in his view good

faith effort—the requirements of 20 of the rule's provisions and had "partially" satisfied the requirements of the other three provisions of the rule. So concluding, he recommended a substantial rate increase. The Superintendent, on the same evidence, determined that Blue Cross had not complied—by what was in his view good faith effort—with four of the requirements of the rule. So concluding, he denied *any* rate increase. An experienced and capable trial judge determined that Blue Cross's good faith effort to comply with every provision of the rule was established by substantial evidence. So concluding, he ordered a substantial rate increase.

Each of these authorities is experienced, each is knowledgeable, each had before him the same evidence of Blue Cross's efforts. They could not have reached such vastly differing conclusions given *any* objective standard: Rather, their differing conclusions are persuasive that the challenged statute does not simply permit, but requires, adjudication wholly subjective.

A statute "violates the first essential of due process" where it

> . . . requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application.

Connally v. *General Construction Co.*, 269 U.S. 385, 391. The challenged statute—vague on its face—has demonstrably caused the Hearing Officer, the Superintendent and the trial court—men of *un*common intelligence—to guess at its meaning. It follows that the challenged statute cannot stand.

It will not do to say the vagueness of the challenged statute could have been cured by a defining judicial construction: The Supreme Court of Ohio has foregone the opportunity to supply the certainty the legislature omitted. It will not do to say the vagueness of the challenged statute is permissible because the statute does not criminalize: That

> . . . is not an adequate distinction. The ground or principle of the decisions was not such as to be applicable only to criminal prosecutions. It was not the criminal penalty that was held invalid, but the exaction of obedience to a rule or standard which was so vague and indefinite as really to be no rule or standard at all. Any other means of exaction, such as declaring the transaction unlawful or stripping a participant of his rights under it, was equally within the principle of those cases.

A. B. Small Co. v. *American Sugar Refining Co.*, 267 U.S. 233, 239. It will not do to say the vagueness of the challenged statute does not penalize Blue Cross: Under color of the statute, the Superintendent has dealt Blue Cross "a financial death blow" (A. 13a) by imposing upon Blue Cross an unexpected and unwarranted loss of millions of dollars. Rather, this Court should recognize the vagueness of the challenged statute for what it is—the hallmark of a statute unconstitutional and void.

II.

The Unforeseeable and Retroactive Judicial Construction of The Ohio Regulatory Statute By The Supreme Court of Ohio Deprived Blue Cross of Due Process of Law. Accordingly, This Case Presents An Important Question of Federal Law Which Has Not Been, But Should Be, Settled By This Court

Frequently a statute which suffers from vagueness as enacted is given a saving gloss of certainty by judicial construction. See, *e.g., Jordan* v. *DeGeorge,* 341 U.S. 223, 227-29, 238-39. In this case, however, Ohio's highest court both failed to give the challenged statute such a saving gloss and attributed to the statute such a startling construction that its application of the statute cannot stand. *Bouie* v. *City of Columbia,* 378 U.S. 347.

In *Bouie,* this Court was faced with a constitutional challenge to a state statute which penalized "entry upon the lands of another . . . after notice from the owner or tenant prohibiting such entry . . . ." The South Carolina Supreme Court, affirming the petitioners' convictions, construed the statute to prohibit not only entry onto the premises of another after warning, but *remaining* on the premises of another after notice to leave.

There the statute was not vague: In fact, the language of the statute was held "admirably narrow and precise." 378 U.S. at 351. Yet this Court reversed, holding that "a deprivation of the right of fair warning can result not only from vague statutory language but also from an unforeseeable and retroactive judicial expansion of narrow and precise statutory language." 378 U.S. at 352. Indeed, the vice of such an unforeseeable construction was held greater than the vice of a vague statute:

> When a statute on its face is vague or overbroad, it at least gives a potential defendant some notice, by virtue of this very characteristic, that a question may arise as to its coverage, and that it may be held to cover his contemplated conduct. When a statute on its face is narrow and precise, however, it lulls the potential defendant into a false sense of security, giving him no reason even to suspect that conduct clearly outside the scope of the statute as written will be retroactively brought within it by an act of judicial construction.

Id. at 352.

The construction which the Supreme Court of Ohio placed on the statute challenged here violates the *Bouie* rule in two respects. First, that Court construed the statutory requirement that Blue Cross use a "combination of education, persuasion and financial incentives and disincentives" as a requirement that Blue Cross use "primarily" "financial incentives and disincentives." (A. 5a) Second, in the teeth of legislative history and unbroken administrative precedent, that Court construed the statute to permit the Superintendent to deny *in toto* actuarially justified rates for partial shortcomings in cost-containment efforts. Neither construction is remotely justified, but—more importantly—even to an institutional litigant habituated to the regulatory process, neither construction was remotely foreseeable.

A. "Combination of persuasion, education, and financial incentives and disincentives" does not give fair notice that it requires "primarily" incentives and disincentives or that "education and persuasion" "should not ordinarily be considered sufficient."

The tools which an association is to use "to encourage" independent hospitals to control costs are set out in the statute: They are "education, persuasion, and financial incentives and disincentives." In the association's "attempt" "to encourage" hospitals to control costs, a "combination" of those tools is to be used. That the association's attempt must include *all* those tools is not disputed here:[3] What is disputed is that Blue Cross could foresee that incentives and disincentives could be deemed "primary" where statutory language and legislative history point to an opposite conclusion.

The legislature ordered Blue Cross, in encouraging independent hospitals to contain costs, to use "persuasion, education and financial incentives and disincentives." As a matter of statutory language, either those tools are of equal importance or those first-listed are of first importance. By no known canon of statutory construction do we come to the statute's "primary" requirements last!

More importantly, in this language, the legislature obviously struck a balance between the view that an association can only persuade, not compel, independent hospitals to contain their costs and the Superintendent's view that, because the Blue Cross Plans *collectively* are a substantial source of hospital income, each

[3] Indeed Blue Cross's attempt did, as the Hearing Officer found, use all the tools required by the statute. (A. 69a)

plan individually has power to compel, rather than persuade. The point here is not that, whenever the legislature has struck one balance between competing views, a court is powerless to strike another, different balance. The point is that, because Ohio's legislature in *this* case, in striking a balance between competing views, set out its requirements in language "admirably narrow and precise," the Supreme Court of Ohio cannot impose an unexpected penalty on Blue Cross by holding it, after the fact, to standards the legislature manifestly did not enact.

B. "Approving only that portion of a proposed . . . rate which he finds to be lawful, fair and reasonable" does not give fair notice that it permits the Superintendent to disapprove in their entirety actuarially justified rates for partial shortcomings in an association's cost-containment efforts.

The construction which the Supreme Court of Ohio placed on the statute challenged here violates the *Bouie* rule in a second respect as well. That Court construed the statute to permit the Superintendent to deny entirely actuarially justified rates for partial shortcomings in Blue Cross's cost-containment efforts. To appreciate the total unforeseeability of that result, a brief historical reference is necessary.

Prior to the amendment of the challenged statute in 1976, the Superintendent sought, under the predecessor statute, to grant an association's requested rates in part. The predecessor statute was construed to deny the Superintendent that power. *In re Blue Cross,* 40 Ohio App. 2d 285, 319 N.E.2d 212 (Ct. App. 1973). When that statute was amended to its present form, the legislature gave the Superintendent the power to

approve that portion of a proposed rate which was lawful, fair and reasonable.[4]

Both the Superintendent and the associations he regulates understood the import of that amendment. As a result, in every ratemaking proceeding between the 1976 amendment and the present case, where an association demonstrated an actuarial need for a rate adjustment, but, in the Superintendent's view, fell short of total compliance with cost-containment efforts, the Superintendent approved the proposed rates in substantial part. The results of those prior adjudications were:

Applicant Hospital Service Association	Date of Order	Percent Granted
Hospital Care Corporation—Canton Division	10/18/77	90%
Hospital Care Corporation—Lima Division	09/23/77	95%
Hospital Care Corporation—Youngstown Division	08/31/77	85%
Blue Cross of Northeast Ohio	08/12/77	80%
Hospital Care Corporation—Cincinnati Division	07/22/77	100%
Blue Cross of Northwest Ohio	03/30/77	70%

[4] The relevant textual change in the predecessor statute is as follows:

> The superintendent shall, within thirty days after the commencement of a hearing issue an order ~~either~~ approving any ~~such~~ PROPOSED contract, amendment, formula, or rate if he finds it to be lawful, fair, and reasonable, OR APPROVING ONLY THAT PORTION OF A PROPOSED CONTRACT, AMENDMENT, FORMULA, OR RATE WHICH HE FINDS TO BE LAWFUL, FAIR, AND REASONABLE, or disapproving any ~~such~~ PROPOSED contract, amendment, formula, or rate if he finds it otherwise. . . .

Amended House Bill No. 448, passed March 4, 1976, approved March 18, 1976, effective June 18, 1976.

The decision in this case departs totally from those precedents and, more importantly, from the language of the statute. The statutory language requires the Superintendent to approve proposed rates if they are lawful, fair and reasonable or to approve "that portion" which is lawful, fair and reasonable. The statutory language authorizes him to disapprove proposed rates in their entirety *only* if he finds the rates unlawful, unfair and unreasonable *in their entirety*. The construction accorded the statute in this case, however, authorizes the Superintendent to disapprove proposed rates in their entirety if he finds fault with any part of any rate. In briefest terms, the statutory language says, "Prove all, win all; prove part, win part." The Supreme Court of Ohio has made that language mean "Prove all, win all; prove part, win none."

As described earlier, the "lawful, fair and reasonable" test has two components: First, the proposed rates must be "in accordance with sound actuarial principles"; second, they must reflect a "good faith effort by a hospital service association to control costs, including both its own administrative costs and costs charged to it by health care facilities, including hospitals." Blue Cross's proposed rates satisfied the "sound actuarial principles" standard. Moreover—in respect of the "good faith effort" component of the statutory test—the Superintendent found only that Blue Cross had not complied with four of the 23 subsections of Rule 3901-1-28 and left undisturbed the Hearing Officer's findings that Blue Cross had complied with every other requirement of the rule. Nevertheless, the Superintendent denied the requested rates in their entirety: The Supreme Court of Ohio affirmed that construction of the statute.

The language of the challenged statute gives no warning that the penalty for substantial, but imperfect, compliance may be "a financial death blow." (A. 13a). Such an unforeseeable construction, imposing retroactively a penalty so substantial, violates the most basic considerations of fundamental fairness. Accordingly, unless *Bouie* is no longer law, the result in this case cannot stand.

III.

The Ohio Regulatory Statute, As Construed By The Supreme Court of Ohio, Deprives Blue Cross of Due Process Because the Administrative Agency Which Applies the Challenged Statute Is Given Limitless Power, Ungoverned By Any Legal Standards, To Disapprove Any or All of Blue Cross's Financially-Justified Rates. Therefore, The Supreme Court of Ohio Has Decided A Substantial Federal Question In A Way Not In Accord With Applicable Decisions of This Court.

All of the Judges of the Court of Appeals (A. 18a) and all of the Justices of the Supreme Court of Ohio (A. 9a) held that the challenged statute provides no standards to govern or guide the Superintendent in determining what portion of an association's actuarially justified rates shall be approved upon finding substantial, but less than total, compliance with the statute's good faith effort requirement. The Court of Appeals unanimously concluded that the absence of such standards invalidated the statute:

> Surely, the General Assembly did not mean to grant unbridled discretion in this critical area. But, sad to say, that is precisely the situation at bar. Both the Blue Cross systems and the reviewing courts are confronted with a totally unpredictable and arbitrary morass in the critical area of rate adjustment. (A. 17a)

The Supreme Court of Ohio held the absence of such standards a matter of no consequence.

That Court stated that:

> If the superintendent determines that Blue Cross has not completely "show[n] . . . that . . . [it] is exerting a good faith effort to control costs," R.C. 1739.051(D) gives him the discretion to approve only "that portion of a proposed . . . rate [increase, if any] which he [nevertheless] finds to be lawful, fair and reasonable." The terms of Paragraph (F) of Rule 3901-1-28 neither limit nor expand this discretion. (A. 8a n.9)

Yet, given that Court's candid recognition that Ohio's legislature did not provide standards to govern or guide the Superintendent in this area, the power given to him is not "discretion in the legal sense of that term," *Yick Wo* v. *Hopkins,* 118 U.S. 356, 366, but arbitrary power, exercisable on such occasions, for such reasons, and for or against such applicants as the Superintendent may for any reason decide. This is not law: It is the absence of law.

This Court has long recognized that a state's delegation of authority to make significant decisions, without effective standards to govern or guide those decisions, violates rights protected by the Fourteenth Amendment. Compare *Seattle Title Trust Co.* v. *Roberge,* 278 U.S. 116 with *Yick Wo* v. *Hopkins, supra.* The delegation of such undifferentiated power is unconstitutional because the person subject to the power's exercise lacks any notice of what factors define or protect his interest, whether it be in life, liberty or property. The vice of such uncanalized power is not simply that the governor may subject the governed

to his "will or caprice," 278 U.S. at 122, it is also that the person subject to the power's exercise cannot—whatever his diligence—comprehend how to guard against the exercise of the power adversely to him. If "law and arbitrary power are in eternal enmity," E. Burke, *Impeachment of Warren Hastings* (1788), it is because arbitrary power makes a mockery of notice and the opportunity for hearing by depriving that which is heard of any operative effect.

The challenged statute gives to the Superintendent power which, the Supreme Court of Ohio has held, is not governed or guided by standards. That the Superintendent may on occasion elect to use that power to grant necessary rate increases in part is established by the Superintendent's six decisions prior to this case. (A. 16a) That the Superintendent may on occasion elect to use that power to deny necessary rate increases *in toto* is established by this case. That the Superintendent may make such ungoverned and unreviewable elections is an affront both to the proposition that this is "a government of laws and not of men," *Yick Wo* v. *Hopkins, supra* at 370, and to the Constitution.

CONCLUSION

For the foregoing reasons, the Writ should be granted.

Respectfully submitted,

JAMES P. KENNEDY, ESQ.
Vorys, Sater, Seymour and Pease
52 East Gay Street
P. O. Box 1008
Columbus, Ohio 43216

Counsel for Petitioner

Of Counsel:

DAVID S. CUPPS, ESQ.
MICHAEL J. CANTER, ESQ.
Vorys, Sater, Seymour and Pease
52 East Gay Street
P. O. Box 1008
Columbus, Ohio 43216

Dated: May 20, 1980

APPENDIX

APPENDIX

BLUE CROSS OF NORTHWEST OHIO, APPELLEE, *v.* JUMP, SUPT. OF INSURANCE, APPELLANT.

[Cite as Blue Cross v. Jump (1980), 61 Ohio St. 2d 246.]

Hospital service associations—Proposed rate increase—Approval by superintendent—R.C. 1739.051(D) and Ohio Adm. Code 3901-1-28(F) constitutional—"Good faith effort" to control costs not satisfied, when—R.C. 1739.01(M) construed.

1. Where there is a need to control hospital costs, and where a hospital service association has not exerted a good faith effort to encourage member health care facilities to control costs by utilizing financial incentives and disincentives, the Superintendent of Insurance can lawfully determine that such hospital service association has failed to satisfy R.C. 1739.01(M).

2. R.C. 1739.01(M) and Paragraph (F) of Ohio Adm. Code 3901-1-28 are not unconstitutionally vague.

3. The determination by the Superintendent of Insurance of whether a hospital service association has exerted a good faith effort to encourage member health care facilities to control costs merely executes R.C. 1739.051 (D) and 1739.01(M).

4. Notwithstanding the discretion given the Superintendent of Insurance to approve a proposed rate increase of a hospital service association, or portion thereof, R.C. 1739.051(D) and Paragraph (F) of Ohio Adm. Code 3901-1-28 are constitutional. (*Matz* v. *J. L. Curtis Cartage Co.*, 132 Ohio St. 271, paragraph seven of the syllabus, approved and followed.)

(No. 79-440—Decided February 20, 1980.)

Appeal from the Court of Appeals for Franklin County

On October 14, 1977, Blue Cross of Northwest Ohio (hereinafter "Blue Cross")[1] filed with the Department of Insurance a request for an average rate increase of 35.9 percent for its non-group subscribers, effective March 1, 1978. On November 29 and 30, and December 1 and 2, 1977, the department held public hearings on the merits of this request, as authorized by R.C. 1739.051(D). Similar hearings were held in February 1977, which resulted in a rate increase for Blue Cross, effective April 30, 1977. At the close of the November-December hearings, the hearing officer concluded that Blue Cross was not in complete compliance with R.C. 1739.01(M) and Department of Insurance Rule 3901-1-28 (Ohio Adm. Code 3901-1-28), and recommended that the average rate increase be limited to 25 percent. Pursuant to his authority under R.C. 1739.051(D) to disapprove Blue Cross' rate request if, *inter alia,* Blue Cross failed to "show by reliable, probative, and substantial evidence * * * [that it was] exerting a good faith effort to control costs," the Superintendent of Insurance, by final order dated January 6, 1978, rejected the hearing officer's recommendation and denied the entire proposed rate increase.

As provided for in R.C. 1739.051(D), Blue Cross appealed this order to the Court of Common Pleas. The court found Blue Cross to be in substantial compliance with the relevant provisions of R.C. Chapter 1739 and Rule 3901-1-28 "since it * * * demonstrated by reliable, probative, and substantial evidence that it has made [*inter alia*] a good faith effort to control costs * * * charged to it by member health care facilities, including hospitals." Therefore, pursuant to R.C. 119.12, the Court of Common Pleas vacated

[1] A Blue Cross plan is a hospital service association and thus regulated under R.C. Chapter 1739, and not under R.C. Title 39 as are commercial insurance companies.

the superintendent's order, and ordered an average 30 percent increase in Blue Cross' non-group rates.

On appeal, the Court of Appeals sustained the trial court's finding, but adjusted the approved rate increase upward to an average 35.9 percent (*i.e.,* Blue Cross' entire request). Alternatively, the Court of Appeals ruled that the discretion given the superintendent by the statute and rule was unconstitutional.

This cause is now before the court pursuant to the allowance of a motion to certify the record.

Messrs. Vorys, Sater, Seymour & Pease, Mr. Robert E. Leach, Mr. James P. Kennedy and *Mr. Michael J. Canter,* for appellee.

Mr. William J. Brown, attorney general, and *Mr. W. Sean Kelleher,* for appellant.

WILLIAM B. BROWN, J. In this cause, we must determine whether the trial court erred in vacating the superintendent's order; and also whether the relevant provisions of R.C. Chapter 1739 are constitutional.

I.

The lawfulness of the trial court's vacation of the superintendent's order depends upon the construction given R.C. 1739.01(M). In relevant part, this section provides:

" 'Good faith effort' means a conscientious, vigorous, and continuing attempt by a hospital service association *through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage member health facilities to control costs* by accomplishing the following objectives: * * *."[2] (Emphasis added.)

[2] R.C. 1739.01(M) then lists the following objectives:

"(1) Elimination of duplicative or unnecessary services and facilities;

The fundamental basis for the superintendent's finding that Blue Cross had not satisfied R.C. 1739.01(M), and for his decision to disapprove Blue Cross' entire proposed rate increase, is that while Blue Cross may have used education and persuasion to encourage hospitals to accomplish certain cost containment objectives, it completely failed to utilize financial incentives and disincentives.[3] The trial court ruled this reading to be "an incorrect interpretation of * * * [R.C. 1739.01(M)]," apparently believing that Blue Cross' good faith effort to use education and persuasion was sufficient to satisfy the statute.

The trial court's interpretation of R.C. 1739.01(M) is not correct. The General Assembly amended R.C. Chapter

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"(2) Nonprovider participation in plan affairs;

"(3) Subscriber support of cost containment activities;

"(4) Promotion of sound management practices in member health care facilities;

"(5) Implementation of sound plan management practices;

"(6) Promotion of alternative forms of care;

"(7) Engagement in, and evaluation of, cost control experiments, including incentive reimbursement and utilization review programs;

"(8) Adoption of other cost containment policies as determined by the superintendent of insurance."

[3] R.C. 1739.051(D) authorizes the superintendent to "issue an order approving any proposed * * * rate, if he finds it to be lawful, fair and reasonable, * * *." R.C. 1739.01(L) defines a lawful, fair and reasonable rate as one "that is in accordance with sound actuarial principles and reflects a good faith effort by a hospital service association to control costs, including both its own administrative costs and costs charged to it by health care facilities, including hospitals." The superintendent concedes that Blue Cross' proposed rate increase is in accordance with sound actuarial principles and reflects a good faith effort by Blue Cross to control its own administrative costs.

1739[4] to require that Blue Cross make a good faith effort to control hospital costs, and made this effort a factor in rate setting, because the Blue Cross plans have the economic leverage and expertise to induce hospitals to become more cost-effective.[5] Education and persuasion of hospitals do not *induce* cost effectiveness, and therefore should not ordinarily be considered sufficient to satisfy R.C. 1739.01 (M). On the other hand, the effectiveness of R.C. 1739.01 (M) in controlling hospital costs depends primarily on Blue Cross' exploitation of its economic leverage over hospitals through the use of financial incentives and disincentives. Blue Cross' compliance with R.C. 1739.01(M) must thus depend primarily on its efforts in this regard.

Therefore, since there was a need for Blue Cross to control hospital costs,[6] and since Blue Cross did not exert a good faith effort to encourage its member hospitals to con-

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[4] Am. H.B. No. 448 (136 Ohio Laws 2546) was amended in 1976 to include R.C. 1739.01(L), 1739.01(M), and various provisions in R.C. 1739.051(D) needed to coordinate these two subsections with the rate-setting process.

[5] During the period Am. H. B. No. 448 was being considered, Blue Cross represented the largest source of hospital income in Ohio. Proposed Regulations Regarding the Practices of Blue Cross Plans in Ohio, Ohio Department of Insurance, May 29, 1974, at page 7. It is also clear that the Blue Cross plans were selected for special legislation because of this economic leverage over hospitals. See Corn & Shkurti, Insurance Regulations to Control the Rising Cost of Health Care: Ohio's New Blue Cross Law, 663 Ins. L.J. 193, 196-205 (1978). See, also, *Blue Cross Hospital Plan* v. *Jump* (1975), 44 Ohio St. 2d 78, 81-82 (Celebrezze, J., dissenting).

[6] The record demonstrates a need to control costs in Blue Cross' area. The trial court's contrary findings are incorrect, especially in light of the limitations placed upon its review of administrative findings by R.C. 119.12. See *Henry's Cafe* v. *Board of Liquor Control* (1959), 170 Ohio St. 233, 235-236 (interpreting *Andrews* v. *Board of Liquor Control* [1955], 164 Ohio 275).

trol costs by utilizing financial incentives and disincentives,[7] the superintendent could lawfully determine that Blue Cross failed to satisfy R.C. 1739.01(M). Thus, the trial court erred in vacating the superintendent's order.

II.

Blue Cross also asserts that the Court of Appeals erred in determining that R.C. 1739.01(M) and Paragraph (F) of Rule 3901-1-28[8] are not unconstitutionally vague.

The Court of Appeals' determination is correct. R.C. 1739.01(M) and Paragraph (F) of Rule 3901-1-28 consist of words and phrases familiar both to Blue Cross and to the superintendent. Moreover, through intelligible guidelines, these provisions together detail types of behavior

[7] The trial court erred under R.C. 119.12 in questioning the superintendent's findings for reason that these findings focused primarily, though not exclusively, on the seven-month period between Blue Cross' rate hearings of February 1977, and the instant hearings. This focus did not render the superintendent's findings "[un]supported by reliable, probative, and substantial evidence." Moreover, this focus is "in accordance with law" because R.C. 1739.01(M) refers to a "conscientious, vigorous, and *continuing* attempt * * * to encourage member health care facilities to control costs * * *." (Emphasis added.) Finally, R.C. 1739.051(D) allocates to Blue Cross the burden of proof on this issue since it provides that "[a]t every public hearing, a *hospital service association must show* by reliable, probative, and substantial evidence that * * * [it] is exerting a good faith effort to control costs." (Emphasis added.)

[8] Ohio Adm. Code 3901-1-28, effective August 19, 1976, recodifying Department of Insurance Rule IN-1739-02 (superseding Emergency Rule IN-1739-01) was promulgated under authority granted to the superintendent by R.C. 1739.051(D) to "develop rules and reporting requirements to indicate activities necessary to establish a good faith effort to control costs." Paragraph (F) of Rule 3901-1-28 repeats the cost containment objectives listed in R.C. 1739.01(M) and, with respect to each objective, describes activities and programs toward which Blue Cross' good faith effort to control costs should be directed. See fn. 2.

expected of Blue Cross. Finally, R.C. 1739.01(M) and Paragraph (F) of Rule 3901-1-28 are not impermissibly vague merely because they require that the superintendent condition his determination on Blue Cross' good faith compliance with these provisions. As the Court of Appeals concluded, "* * * there is certainly no dearth of case law on the matter [of good faith], and one must assume that duly appointed administrators will allow common sense to prevail."

III.

Blue Cross next argues that the discretion given the superintendent to determine whether Blue Cross has exerted a good faith effort to control hospital costs is an unlawful delegation of legislative authority.

This argument is without merit because the above determination merely executes R.C. 1739.051(D) and 1739.01(M). First, R.C. 1739.01(M) fixes the factors that the superintendent must consider both in rule making and in adjudication. Second, R.C. 1739.051(D) details mandatory procedures applicable to adjudication. Third, R.C. 1739.051(D) also provides for judicial review under R.C. 119.12. Finally, Paragraph (F) of Rule 3901-1-28, which assists the superintendent in making this determination, was promulgated under the authority of R.C. 1739.051(D). Accord *Strain* v. *Southern* (1947), 148 Ohio St. 153. See *Belden* v. *Union Cent. Ins. Co.* (1944), 143 Ohio St. 329, paragraph three of the syllabus.

IV.

Blue Cross finally argues that the discretion given the superintendent to partially approve a proposed rate request is an unlawful delegation of legislative authority. Blue Cross' specific objection is that, as is true, neither R.C. 1739.051(D) nor Paragraph (F) of Rule 3901-1-28

expressly guides the superintendent in making this apportionment.[9]

We hold that this lack of express guidance does not invalidate these provisions. When the General Assembly delegates power to an administrative official, it must provide standards insofar as it is possible to do so. See *Coady* v. *Leonard* (1937), 132 Ohio St. 329, 332. In the instant cause, however, Blue Cross has not suggested, nor does the record disclose, any standards which the superintendent could possibly employ to determine the portion of a rate request to approve, if he finds Blue Cross not in complete compliance with the cost containment provisions. Indeed, given the economic premises of the cost containment provisions,[10] it is unlikely that the General Assembly could draft standards limiting the superintendent's discretion in a manner satisfactory to Blue Cross *without* undermining the effectiveness of these provisions.

The absence of specific standards in a law conferring authority on an administrative official is not necessarily unlawful. In *Matz* v. *J. L. Curtis Cartage Co.* (1937), 132

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[9] If the superintendent determines that Blue Cross has not completely "show[n] * * * that * * * [it] is exerting a good faith effort to control costs," R.C. 1739.051(D) gives him the discretion to approve only "that portion of a proposed * * * rate [increase, if any] which he [nevertheless] finds to be lawful, fair and reasonable." The terms of Paragraph (F) of Rule 3901-1-28 neither limit nor expand this discretion.

[10] The General Assembly amended R.C. Chapter 1739 to include the cost containment provisions to exploit Blue Cross' economic leverage over hospitals. It decided to monitor Blue Cross' good faith efforts, rather than to impose mandatory programs, in order to encourage innovation, to exploit Blue Cross' expertise, and perhaps to avoid the pitfalls of more extensive regulation. It chose to monitor Blue Cross' good faith efforts as part of the rate-setting process in order to exploit fully the Department of Insurance's economic leverage over the Blue Cross plans. See, generally, Corn & Shkurti, fn. 5, *supra*.

Ohio St. 271, paragraph seven of the syllabus, this court held:

"As a general rule a law which confers discretion on an executive officer or board without establishing any standards for guidance is a delegation of legislative power and unconstitutional; but when the discretion to be exercised relates to a police regulation for the protection of the public morals, health, safety or general welfare, and it is impossible or impracticable to provide such standards, and to do so would defeat the legislative object sought to be accomplished, legislation conferring such discretion may be valid and constitutional without such restrictions and limitations." [11]

With respect to the superintendent's discretion to partially approve a proposed rate increase, the General Assembly has made the policy decision that "it * * * [would be] impossible or impracticable to provide * * * [specific] standards, and [that] to do so would defeat the legislative object sought to be accomplished * * *." Nothing in the record, or in the nature of the problem, suggests that this decision is unreasonable. Therefore, we hold that R.C. 1739.051(D) and Paragraph (F) of Rule 3901-1-28 are constitutional, notwithstanding the discretion given the superintendent to approve a proposed rate increase or portion thereof.

Accordingly, the judgment of the Court of Appeals is reversed.

Judgment reversed.

CELEBREZZE, C. J., SWEENEY, LOCHER and HOLMES, JJ., concur.

HERBERT and P. BROWN, JJ., dissent.

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[11] See, also, *Weber* v. *Board of Health* (1947), 148 Ohio St. 389, paragraph two of the syllabus; *State* v. *Switzer* (1970), 22 Ohio St. 2d 47, 50; and *State* v. *Schreckengost* (1972), 30 Ohio St. 2d 30, 32-33.

PAUL W. BROWN, J., dissenting. Where a burden of proof is imposed upon a party such as that imposed upon Blue Cross and other hospital service associations under this statute, a definitive, prospective and understandable statement of what is to be proven must be fairly discoverable from the terms of the legislation or from rules provided pursuant to a lawful delegation of that power to the administrative agency. To that end the delegation must be rationally circumscribed and rules designed to implement the delegation must directly relate to legitimate regulatory goals of the agency.

I perceive that the incorporation of "good faith effort" cost containment goals into the rate-making function of the Department of Insurance represents a standard so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application. I conclude that the delegation violates fundamental notions of due process and that the statutory scheme is to such extent unconstitutional.

HERBERT, J., concurs in the foregoing dissenting opinion.

IN THE COURT OF APPEALS OF FRANKLIN COUNTY, OHIO

No. 78AP-450

BLUE CROSS OF NORTHWEST OHIO,
Plaintiff-Appellee, (Cross-Appellant),

v.

HARRY V. JUMP, Director of Insurance,
Department of Insurance,
Defendant-Appellant.

DECISION

Rendered on January 25, 1979

VORYS, SATER, SEYMOUR & PEASE,
MR. JAMES P. KENNEDY,
MR. MICHAEL J. CANTER and
MR. MARK T. DYKSTRA, of Counsel,
52 East Gay Street,
Columbus, Ohio,
For Blue Cross of Northwest Ohio.

MR. WILLIAM J. BROWN, Attorney General,
MR. W. SEAN KELLEHER, Assistant,
State Office Tower,
30 East Broad Street,
Columbus, Ohio,
For Harry V. Jump, Director
of Insurance.

WRIGHT, J., sitting by assignment.

I

This is an appeal by the Superintendent of the Department of Insurance (Superintendent) from a judgment of the Court of Common Pleas of Franklin County, reversing an order denying in its totality a request by Blue Cross

of Northwest Ohio (Blue Cross) for an increase in rates for various categories of its coverage. The request prayed for a 35.9 percent increase for nongroup subscribers effective March 1, 1978. It should be stressed the Superintendent nowhere questions the need for the sought after rate increase on the basis of sound and unquestioned actuarial principles. Indeed, it is undisputed that there is an immediate need for implementation of the proposed rate hike.

The trial court made an exhaustive review of the record and found that the Superintendent's order was not supported by reliable, probative and substantial evidence and was not issued in accordance with law. Additionally, the trial judge made a finding that an increase of 30 percent was lawful, fair and reasonable. Blue Cross filed a cross-appeal raising constitutional issues not dealt with by the trial judge and asserting the propriety of the total request as noted, *supra*. The Superintendent moved for dismissal of the cross-appeal and this court overruled said motion, ruling that said appeal was timely filed.

Appellant raises three assignments of error. The first claims that burden of proof was placed on the Superintendent with respect to the requirement that Blue Cross must demonstrate a "good faith" effort to achieve the statutory goals of cost containment for health care. Certain portions of the trial court's opinion might be so construed. The totality of the decision requires a different conclusion. Further, it must be noted that we are dealing with an appeal pursuant to R. C. 119.12. Thus, regardless of where the burden may lie, the Superintendent's order must be lawful and must contain some reliable, substantial and probative evidence in support thereof. The trial judge conducted a careful and comprehensive review of the record and found it devoid of these standards. We concur with the conclusion. Consequently, the first assignment of error must be overruled.

Secondly, appellant claims that the trial court erred in holding that Blue Cross made a "good faith" effort in the cost containment areas as defined in § (F)(1)(b) of Rule 3901-1-28. Specifically, appellant notes that regardless of a mass of demonstrable activities in these areas, the Superintendent's definition of said standards remains unsatisfied since the Superintendent remains convinced that there is a 400-bed excess level within appellee's service area. Blue Cross had been warned that efforts should be made to correct this situation. The trial court dealt with this contention by pointing out that it was impossible to determine from the record whether or not the Superintendent's position is correct due to the failure of the appropriate planning agencies to develop the criteria contemplated by § (F)(1)(b) of the Rule. The record reflects a number of activities by Blue Cross designed to hold down bed levels, but no "results" were documented if one begins with the premise adopted by the Superintendent. It will not suffice for a reviewing court to be compelled to guess at the theory underlying a decision by any administrative agency.

We concur with the trial court for another reason. The legislative mandate contained in R. C. 1739.051 calls for "good faith" *efforts*. Neither the General Assembly nor the Superintendent equated "good faith" efforts with "results" until the Superintendent denied the totality of the rate increase requested in his order of January 6, 1978. We believe the Superintendent's order in the context of this case amounts to the most flagrant form of rule-making by adjudication. That is to say, the order appealed from retroactively promulgated a standard of performance required of Blue Cross far beyond a statutory authority announced by the General Assembly.

To make matters even worse, the Superintendent would deal Blue Cross a financial death blow for failure to accomplish a task that borders on the impossible given the time

frame involved and the weaponry available. This is precisely the type of conduct that this and other courts have deplored as a denial of property without due process of law. See, e.g., *In Re Blue Cross* (1974), 44 Ohio App. 2d 375; *In Re Application of Blue Cross* (1973), 40 Ohio App. 2d 285; and, *In Re Application of Blue Cross* (1972), 34 Ohio Misc. 29. It might be argued that the facts at bar meet the requisites for rule-making through the adjudicatory process found in *Securities & Exchange Commission v. Chenery* (1947), 332 U.S. 194. *Chenery* may or may not control in this state but, unlike the truly novel facts in that case, this case clearly doesn't pose problems for which "* * * the administrative agency could not reasonably foresee, problems which must be solved despite the absence of a relevant general rule. * * *" *Chenery, supra,* at page 202. For a more definitive discussion of the scope of *Chenery,* see *In Re Application of Blue Cross, supra,* at pages 32 to 38.

In any case, we find the trial court's posture a correct one for the further reason that the Superintendent's order is both arbitrary and discriminatory. As indicated, Blue Cross has no direct control over excess bed levels absent blacklisting the offending health providers, a rule not as yet announced by the Superintendent—a final solution, if you will. Assignment of error number two must be overruled.

Appellant's third assignment of error involves a claim that Blue Cross failed to comply with §§ (F)(4), (F)(6), and (F)(7) of Rule 3901-1-28, and the trial court erred in giving credence to the testimony presented by appellee. Counsel notes that the record contains nothing but testimony from witnesses called by Blue Cross to bolster its position and concluded that this fact in effect taints the entirety of this portion of the record as inherently unreliable. This court rejects this truly unusual position. It should be noted that the hearing officer reached a contrary

position to that of appellant and in his careful dissection of the Superintendent's order the trial judge searches in vain for any basis for the Superintendent's conclusion. This assignment of error has no merit and must be overruled.

II

In the first and second assignments of error on its cross-appeal, Blue Cross, among other things, claims that the Superintendent's order is based on an *Ad Hoc* standard of conduct without any definitive basis under either R. C. 1739.051 or his own rules. As noted above, we concur. The legislative mandate defines a "good faith effort" as a "*continuing* attempt * * * to control costs and *encourage* member health care facilities of control costs * * *." (Emphasis added.) R. C. 1739.01(M). This laudatory policy statement recognized that the sundry Blue Cross organizations throughout the state are in a unique position to persuade and exert influence, but have no final authority in the area of health care. The Superintendent wrongfully transformed a mandate for the exercise of continuing and persistent diplomacy to the running of the war.

Appellee would have us go further and declare as unconstitutional the whole of the statutory and rule-making framework on the grounds of vagueness. In a word, Blue Cross complains that the definitions involved are so unprecise and illusory as to deny appellee due process of law. Blue Cross argues that it is subject to the uncontrolled whim of the occupant of the office of the Superintendent. This argument has a certain facial attraction when confronted with the facts at bar. However, we need not and should not go so far in light of controlling case law which militates that the judiciary should give every intendment of constitutionality to a legislative pronouncement. Appellee makes much of the truism that a "good faith" effort in the light of one person might leave another man with a contrary impression. However, there is certainly no dearth

of case law on the matter, and one must assume that duly appointed administrators will allow common sense to prevail. See, e.g., *National Labor Relations Board v. National Shoes, Inc.*, (1953), 208 F. 2d 688.

Thus, for the reasons stated appellee's assignments of error numbered one and two are sustained in part and overruled in part.

Appellee's third assignment of error attacks both the order of the Superintendent and the ultimate conclusion of the trial judge on constitutional grounds. The Superintendent denied the whole of the rate request, citing as his only ground appellee's failure to exercise "good faith" efforts as noted above. This all-or-nothing approach was contrary to his treatment of similarly situated hospital care corporations in six other instances.[1]

There was no explanation for this seeming disparity of treatment. In truth, neither the statute nor the rule deals with what, if any, portion of an otherwise justified rate increase may be deducted following a finding of partial compliance with the "good faith" standard. In this area the statutory scheme is not just vague but, rather, standards for adjudication are non-existent. We believe that this illustrates the inherent constitutional problems of attempting to effectuate a broad public policy goal through the rate making process. For a further discussion of this

[1] "HOSPITAL SERVICE ASSOCIATION — DATE OF ORDER — % GRANTED

Hospital Care Corporation—Canton Division	10/18/77	90%
Hospital Care Corporation—Lima Division	9/23/77	95%
Hospital Care Corporation—Youngstown Division	8/31/77	85%
Blue Cross of Northeast Ohio	8/12/77	80%
Hospital Care Corporation—Cincinnati Division	7/22/77	100%
Blue Cross of Northwest Ohio	3/30/77	70%"

thesis, see *In Re Application of Blue Cross, supra,* at pages 40 to 42. Therein it was suggested that the Superintendent could be granted the power to impose specific requisites on a Blue Cross organization on a prospective basis as part of the licensing process. See also, *National Labor Relations Board v. Majestic Weaving Co., Inc.*, (1966), 355 F. 2d 854.

As indicated above, this court would avoid declaring a statutory enactment as unconstitutional; however, in the case at bar the trial court reversed the Superintendent's order, then, without any explanation whatsoever, allowed approximately 85 percent of the increase. We can find no rationale for the trial judge's action in this respect.

Surely, the General Assembly did not mean to grant unbridled discretion in this critical area. But, sad to say, that is precisely the situation at bar. Both the Blue Cross systems and the reviewing courts are confronted with a totally unpredictable and arbitrary morass in the critical area of rate adjustment.

There is no doubt that the General Assembly may establish policy goals in matters of broad public interest such as cost containment. However, accompanying said goals must be precise standards for the guidance of administrative bodies with respect to implementing these goals. See *Belden v. Union Central Life Insurance Co.* (1944), 143 Ohio St. 329. We recognize that this is easier said than done, and note the inherent constitutional problems in setting definitive standards for cost containment by third parties and introducing same into the calculation of fair and reasonable rates. Appellee's third assignment of error is sustained.

Appellee's assignment of error number four argues that the Superintendent has indulged in rule-making by adjudication. We agree and this assignment of error is sustained

for the reasons outlined in our prior discussion of appellant's assignment of error number two.

Thus, the judgment of the trial court is affirmed in part and modified in part, and this court will order an immediate implementation of the rate adjustments proposed in the application of Blue Cross under date of October 14, 1977, and the full and immediate approval of the two new contracts included in said application.

STRAUSBAUGH and REILLY, JJ., concur.

WRIGHT, J., of the Court of Common Pleas, Franklin County, Ohio, sitting by assignment in the Tenth District Court of Appeals, Franklin County, Ohio.

COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO

Case No. 78CV-01-167

BLUE CROSS OF NORTHWEST OHIO

Appellant

vs.

HARRY V. JUMP, DIRECTOR OF INSURANCE
DEPARTMENT OF INSURANCE

Appellee

DECISION

Rendered this 13th day of June, 1978.

TYACK, J.

This matter is before the Court upon an appeal taken pursuant to R.C. 119.12. Appellant is Blue Cross of Northwest Ohio, Inc. ("BCNWO"), a nonprofit hospital service association operated pursuant to Chapter 1739 of the Ohio Revised Code. BCNWO provides hospital coverage to subscribers at member hospitals located in Toledo and northwest Ohio. The appellee is the Superintendent of Insurance.

This appeal is taken from an Order and Journal Entry of the Superintendent, dated January 6, 1978, denying in full a request by BCNWO to adjust or establish, effective March 1, 1978, rates for its existing Non-Group 70 Day and Non-Group Medicare Complementary coverage and for its new High Option and Low Option-120 Day coverage.

R. C. 1739.051 provides *inter alia* that if any hospital service association desires to establish or change any rate charged for any subscriber contract, other than for a group rate for group subscriber contracts, a copy of the proposed rate shall be filed with the Superintendent of Insurance and shall not be effective until the expiration of 90 days after the filing thereof. The statute further pro-

vides that if the Superintendent is not satisfied within such 90-day period that every portion of any such rate is lawful, fair, and reasonable, he shall either so notify such association and it shall thereafter be unlawful for such association to use any such rate, or that portion or portions of the rate which he finds to be unlawful, unfair, or unreasonable, or he shall set a date and time for a public hearing to commence no later than 90 days after receipt of said filing. Finally, the Superintendent is required, within 30 days after the commencement of a hearing, to issue an Order approving any proposed rate if he finds it to be lawful, fair, and reasonable, or approving only that portion of a proposed rate which he finds to be lawful, fair, and reasonable, or disapproving any proposed rate if he finds it otherwise. R.C. 1739.051 requires that any action by the Superintendent following a public hearing shall be effective by written order which shall state the grounds for disapproval.

"Lawful, fair, and reasonable" is defined in R.C. 1739.01 (L) to mean a rate that is established in accordance with sound actuarial principles and reflects a good faith effort by a hospital association to control costs, including both its own administrative costs and costs charged to it by health care facilities, including hospitals.

R.C. 1739.01(M) defines "good faith effort":

> 'Good faith effort' means a conscientious, vigorous, and continuing attempt by a hospital service association through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage member health care facilities to control costs by accomplishing the following objectives:
>
> (1) Elimination of duplicative or unnecessary services and facilities;
>
> (2) Nonprovider participation in plan affairs;

> (3) Subscriber support of cost containment activities;
>
> (4) Promotion of sound management practices in member health care facilities;
>
> (5) Implementation of sound plan management practices;
>
> (6) Promotion of alternative forms of care;
>
> (7) Engagement in, and evaluation of, cost control experiments, including incentive reimbursement and utilization review programs;
>
> (8) Adoption of other cost containment policies as determined by the superintendent of insurance.

BCNWO filed with the Superintendent of Insurance, on October 14, 1977, its application to increase existing rates for its non-group subscribers by an average of 35.9%. The rates requested are as follows:

Non-Group 70 Day 80/20

	Current		Proposed	
	S	F	S	F
Bank	23.90	45.45	34.05	67.80
Direct Pay	25.20	49.80	35.85	71.35

Non-Group 70 Day Comprehensive

	Current		Proposed	
	S	F	S	F
Bank	27.70	52.55	36.60	72.90
Direct Pay	29.15	57.55	38.55	76.75

NEW High Option-120 Day Comprehensive

	S	F
Bank	38.35	76.50
Direct Pay	40.30	80.40

NEW Low Option-120 Day 80/20

	S	F
Bank	31.15	62.10
Direct Pay	32.70	65.30

The Superintendent conducted a public hearing in Toledo regarding the proposed rates. A great deal of testimony and many exhibits were submitted into the record at the hearing, which resulted in a transcript of 1350 pages.

The hearing officer issued a report and recommendation on December 23, 1977, concluding that BCNWO had demonstrated financial need for the requested rates, but that it was in only partial compliance with the cost containment provisions of Department of Insurance Rule 3901-1-28. The hearing officer recommended that an average 25% rate increase be approved. The Superintendent's Order and Journal Entry, which was issued on January 6, 1978, denied BCNWO's rate application in its entirety.

R.C. 119.12 provides this Court may affirm the Order of the Superintendent if it finds, upon consideration of the entire record and such additional evidence as the Court has admitted, that the Order is supported by reliable, probative, and substantial evidence and is in accordance with law. In the absence of such a finding, this Court may reverse, vacate, or modify the Order or make such other ruling as is supported by reliable, probative, and substantial evidence and is in accordance with law.

Four motions are before the Court to admit additional evidence into the record of this appeal. BCNWO has submitted for admission Reports, Recommendations, Orders, and Journal Entries concerning 1977 applications of other Blue Cross plans to adjust rates. The Court finds these documents are administrative agency precedent of which the Court may take judicial notice. No question is raised as to their authenticity. Therefore, the Reports, Recommendations, Orders, and Journal Entries submitted as part of Appendix I, Brief of the Appellant Blue Cross of Northwest Ohio, shall be admitted.

BCNWO also seeks the admission into the record of the Final Report of the Ohio Senate Oversight Subcommittee on Amended H. B. 448 and the Public Rebuttal of the Department of Insurance to the Final Report of the Ohio Senate Oversight Subcommittee on Amended H. B. 448. The Court finds that these documents are relevant to this appeal and could not have been discovered with reasonable diligence prior to the administrative hearing. Therefore, they shall be admitted.

The Superintendent seeks to have admitted into the record of this appeal testimony of Howard Franz, August 5, 1976, *In The Matter Of Public Hearing On Proposed Rule IN-1739-02.* BCNWO does not object to the admission of this testimony. It shall be admitted.

Under the standard set forth in Chapter 1739, the rates applied for must be established in accordance with sound actuarial principles. The Court, having reviewed the testimony and exhibits finds the proposed rates are established in accordance with sound actuarial principles. The Superintendent's Order and Journal Entry is in agreement with this conclusion. I find, therefore, that the proposed rates are lawful, fair, and reasonable in so far as they are required to be established in accordance with sound actuarial principles.

A hospital service association must also demonstrate that the rates sought reflect a good faith effort to control costs.

Pursuant to R.C. 1739.051(D), the Superintendent has promulgated Department of Insurance Rule 3901-1-28 OAC which requires a hospital service association to exert a good faith effort in 23 separate cost containment activities. The Superintendent found BCNWO in compliance with 19

of the 23 requirements of the Rule. The Superintendent found BCNWO had failed to comply with Subsections (F)(1)(b), (F)(4), (F)(6), and (F)(7) of the Rule.

Subsection (F)(1)(b) of Department of Insurance Rule 3901-1-28 provides that a hospital service association must demonstrate a good faith effort to accomplish the following objectives:

> (1) Elimination of duplicative or unnecessary services or facilities by:
>
> * * *
>
> (b) making a good faith effort to have member hospitals consolidate, share, convert or phase out inappropriate or unnecessary services or facilities under criteria developed by the appropriate planning agencies, and consistent with the State Plan for Health Facilities of the Ohio Department of Health issued pursuant to Section 3701.39 of the Ohio Revised Code.

Before the Superintendent may deny a rate application in whole or in part on the basis of compliance with Subsection (F)(1)(b), the appropriate local planning agencies must have developed the criteria contemplated by the Rule. *See,* the Report and Recommendation of the Hearing Officer and Order and Journal Entry rendered *In the Matter of the Application of Hospital Care Corporation, Canton Division, for an Adjustment of Rates Charged to Non-Group Subscribers* (October 11, 1977). The evidence establishes that BCNWO is in compliance with Subsection (F)(1)(b) because no criteria have been developed by the appropriate local planning agency.

Furthermore, Subsection (F)(1)(b) does not place upon a hospital service association the responsibility to develop such criteria. The record indicates that the expertise necessary for such an undertaking rests with local, state, and federal planning agencies.

Much of the testimony regarding BCNWO's compliance with Subsection (F)(1)(b) focused on the plan's efforts to identify and eliminate excess beds in its area. Citing evidence which this Court finds to be unreliable, the Superintendent stated that more than 400 excess beds exist in BCNWO's area. The evidence establishes that the 400 excess bed figure represents an estimate of the community's projected needs for the year 1981. No evidence was adduced regarding the adequacy of the area's present bed complement. Furthermore, the 400 bed figure represents certified beds, not beds actually in service. Substantial evidence was introduced establishing a disparity between the number of certified beds and the number of beds actually in use. Accordingly, it is not possible to determine from the present record whether excess beds presently exist within BCNWO's service area.

Testimony of Blue Cross witnesses establish the substantial efforts by the plan of the type contemplated by Subsection (F)(1)(b). The record shows that BCNWO initiated the consolidation and conversion of duplicative bed facilities in Sandusky, Ohio; opposed a proposal to add 90 beds to St. Luke's Hospital, yielding a savings of $6,000,000; opposed a proposal to add beds and other facilities at New London Hospital; promoted the closing of a hospital's obstetric unit and prevented the reopening of certain beds within another hospital, and is currently involved in reducing the obstetric unit at yet another hospital; achieved an agreement, as a result of meetings with certain hospital trustees, for the consolidation of certain duplicative facilities; is opposing and attempting to limit the extent of construction of a new health care facility in a rural community to insure that it corresponds to a demonstrated need in that community; opposed a hospital's decision to staff unnecessary facilities; identified various services which may be consolidated; formulated recommendations, and urged hospitals to adopt these recommendations; provided financial incentives to all hospitals

participating in the Clinical Engineering Center, to three hospitals sharing security and printing services, to several hospitals sharing physical therapists, respiratory therapists, and dietitians, to hospitals participating in a bulk oxygen purchasing program, to four hospitals using a cooperative billing system, and to all hospitals sharing certain management services. The fact that certain of the foregoing activities may have occurred prior to BCNWO's last rate hearing, or may not yet be completed, does not detract from their probative value as evidence of BCNWO's good faith effort to accomplish the objectives of Subsection (F)(1)(b).

Upon review of the entire record, this Court finds that BCNWO has established by reliable, probative, and substantial evidence its compliance with Subsection (F)(1)(b) and that it was error for the Superintendent to deny the rates requested upon his finding that BCNWO had failed to comply with Subsection (F)(1)(b).

Subsection (F)(4) of Department of Insurance Rule 3901-1-28 provides that a hospital service association must demonstrate a good faith effort to accomplish the following objectives:

> (4) Promotion of sound management practices in member health care facilities by:
>
> (a) Making a good faith effort to encourage member health care facilities to develop purchasing policies to assure prudent buyer practices.
>
> (b) Making a good faith effort to have member health care facilities establish a bad debt control program as a precondition to Plan reimbursement for the member health care facilities' bad debts. Such a program shall include but need not be limited to, compliance with standard criteria by type of health care facility and patient mix developed by the Plan and containing as a minimum, the following elements: (1) data collection, including age of accounts receivable by the type of payment mechanism; (2) financial counseling; (3) classification of charity patients; and (4) collection procedures.
>
> (c) Making a good faith effort to have member health care facilities establish, maintain and utilize appropriate financial and statistical information systems.
>
> (d) Making a good faith effort to have member health care facilities employ management techniques such as industrial engineering.

The Superintendent found that BCNWO had failed to make a good faith effort in the use of education, persuasion, financial incentives and financial disincentives to promote sound management practices in member health care facilities and, therefore, it was not in compliance with Subsection (F)(4). The Superintendent stated that BCNWO must engage simultaneously in each of the four activities set forth in Subsection (M) of R. C. 1739.01. The Court is of the opinion that this is an incorrect interpretation of the statute. Upon review of the entire record, this Court finds that the Superintendent's finding is contrary to the evidence, and is not in accordance with law.

The record shows the following activities of the type which demonstrate compliance with Subsection (F)(4): Continuous surveys of member hospitals to insure prudent buying practices; examination and analysis of the purchasing policies of all member hospitals by use of an internal control questionnaire; development and implementation of a program to analyze hospitals' supply purchases; opposition to imprudent purchasing practices; successful opposition of an imprudent lease transaction at New London Hospital, resulting in a savings of $21,000; routine review and analysis of the bad debt control programs of member hospitals; utilization of a bad debt ques-

tionnaire developed for this purpose; limitation of bad debt allowances to three percent; demanding effective bad debt control programs in contractual rate negotiations; audit reviews of bad debt programs, which have yielded reimbursement reductions of over $200,000; promotion of valid statistical information systems in member health care facilities; requirement that member hospitals file annual statements of reimbursable costs on a uniform cost report; successful promotion of the use of standardized statistical information systems; implementation of a standardized statistical information system known as the Joint Profile System; successful promotion of the use of Ohio Hospital Management Services; reimbursement of member hospitals for the utilization of industrial engineering services; contribution of $7,800 in support of Ohio Hospital Management Services programs; offering financial incentives to member hospitals to utilize CPA management reports; and promotion of the utilization of management consulting and industrial engineering firms.

Subsection (F)(6) of the Department of Insurance Rule 3901-1-28 provides that a hospital service association must demonstrate a good faith effort to accomplish the following objectives:

> (6) Promotion of alternative forms of care by making a good faith effort to have health care facilities develop alternatives to inpatient care such as outpatient hospital services, ambulatory health facilities, as defined in Section 1739.01(K), of the Ohio Revised Code, home health care services and skilled nursing facility services.

Subsection (F)(6) is intended to encourage the development of alternatives to inpatient care. The record shows that BCNWO made significant efforts to encourage member health care facilities to develop pre-admission testing programs, outpatient psychiatric programs, home health care

programs, ambulatory surgical care programs, outpatient physical and occupational therapy programs, coordinated home care programs, home hemophilia programs, and an outpatient diagnostic program. The Superintendent's finding that BCNWO failed to assert a good faith effort to achieve the goals of Subsection (F)(6) is not supported by reliable, probative, and substantial evidence. BCNWO established by requisite quantum and quality of evidence its compliance with Subsection (F)(6) of the Rule.

Subsection (F)(7) of Department of Insurance Rule 3901-1-28 requires that a hospital service association demonstrate a good faith effort to accomplish the following objectives:

> (7) Engagement in and evaluation of cost control experiments, including incentive reimbursement and utilization review programs. Such activities shall include, but need not be limited to experimentation by the Plan and member health care facilities with alternative forms of care, and participation by the Plan and member health care facilities in periodic evaluations of cost control activities.

Subsection (F)(7) requires a hospital service association to demonstrate a good faith effort to engage in and evaluate cost control experiments, including incentive reimbursement and utilization review. With respect to utilization review, the record shows that all member hospitals within BCNWO's area have utilization review committees, that BCNWO has successfully used persuasion and financial incentives to promote these utilization review committees, and that BCNWO offers financial incentives for concurrent utilization review of all patient cases. Furthermore, the record demonstrates that BCNWO initiated discussions with Blue Shield regarding the development of coordinated utilization review, that BCNWO itself performs periodic utilization review surveys in member hospitals and participates in utilization review committee

meetings at member hospitals, and that BCNWO employs three nurses for the sole purpose of reviewing claims. Their efforts have resulted in an annual savings of $340,000.

Subsection (F)(7) also requires a hospital service association to demonstrate a good faith effort to engage in and evaluate incentive reimbursement. The record shows that BCNWO has developed and implemented a prospective incentive reimbursement system in its contracts with all member hospitals under which hospital charges are prospectively negotiated. BCNWO pays no more than a percentage of a hospital's prospectively negotiated controlled charges, subject to further cost control limitations applied at the end of each fiscal year. Negotiated charges are approved by the Hospital Payment Committee, a majority of whom are consumer representatives. BCNWO's prospective incentive reimbursement system has yielded substantial savings. The record also establishes that BCNWO has engaged in an experimental Enhanced Incentive Reimbursement Program, which began on a pilot basis in January of 1978.

BCNWO has also demonstrated a good faith effort to develop and implement a Joint Profile System. BCNWO has submitted evidence that, since the early part of 1977, it has taken steps towards implementation of a system, and set December, 1977 as the target date for its initial data analysis.

The record shows that the Superintendent's finding of non-compliance lacks the support of reliable, probative, and substantial evidence, and is not in accordance with law. The evidence, as reviewed above, establishes that BCNWO has demonstrated its compliance with Subsection (F)(7) of Department of Insurance Rule 3901-1-28.

Upon consideration of the entire record, this Court finds that BCNWO is substantially in compliance with the stand-

ards set forth in R.C. 1739.051(D) and Rule 39091-1-28, since it has demonstrated by reliable, probative, and substantial evidence that it has made a good faith effort to control costs, including its own administrative costs, as well as costs charged to it by member health care facilities, including hospitals.

Now, therefore, the Court having found that BCNWO has substantially complied with R.C. 1739.051 hereby VACATES the Superintendent's Order of January 6, 1978, and ORDERS that an average thirty percent (30%) increase in existing non-group rates is lawful, fair, and reasonable, and that the rates for the new contracts are lawful, fair, and reasonable as proposed. Such rates may be implemented upon the filing of this Court's Entry with the Clerk.

/s/ GEORGE E. TYACK
George E. Tyack, Judge

Appearances:

Superintendent of Insurance
Department of Insurance

Attorney General of Ohio
Karen Grant
Assistant Attorney General

Vorys, Sater, Seymour & Pease
James P. Kennedy, Esq.
Counsel for Blue Cross of Northwest Ohio

STATE OF OHIO
DEPARTMENT OF INSURANCE

ORDER AND JOURNAL ENTRY

IN THE MATTER OF THE APPLICATION OF BLUE CROSS OF NORTHWEST OHIO FOR APPROVAL OF CERTAIN RATES CHARGED TO INDIVIDUAL SUBSCRIBERS

Blue Cross of Northwest Ohio is a hospital service association licensed pursuant to Chapter 1739, Ohio Revised Code. Blue Cross of Northwest Ohio ("BCNWO") is domiciled in Toledo, Ohio. On October 14, 1977 BCNWO filed with the Ohio Department of Insurance a request for rate increases for certain individual subscriber contracts. Said filing also included a request by BCNWO for approval of rates for two new individual subscriber contracts.

Pursuant to Section 1739.051, Ohio Revised Code, a premium rate requested by a hospital service association cannot be approved by the Ohio Department of Insurance unless the Superintendent of Insurance finds that those rates to be [sic] "lawful, fair and reasonable." "Lawful, fair and reasonable" means both that BCNWO has made a good faith effort in the area of cost containment and that the rates which were filed with the Ohio Department of Insurance on October 14, 1977 were developed in accordance with sound actuarial principles. Cost containment activities are to be carried on through a combination of education, persuasion, financial incentives and financial disincentives, pursuant to Section 1739.01 (M).

Pursuant to Section 1739.051 a public hearing was conducted by the Ohio Department of Insurance in Toledo, Ohio on November 29 and 30 and December 1 and 2, 1977. The purpose of said public hearing was to hear testimony and compile evidence relating to this matter. Appropriate notice of this hearing was given to both BCNWO and the public.

Upon consideration of the Hearing Officer's Report and Recommendation to the Superintendent of Insurance, the record and exhibits, we agree with the Hearing Officer that the premium rates requested by BCNWO were developed in accordance with sound actuarial principles. The record makes it clear that BCNWO experienced an underwriting loss on its individual contracts of $3,816,283.71 for the period of July, 1976 through June, 1977. Extensive cross-examination by the Ohio Department of Insurance did not controvert the actuarial methodology used by BCNWO. Therefore, it is my finding that the proposed rates were developed using standard actuarial principles, and that these actuarial principles produced credible results.

Ohio Department of Insurance Rule 3901-1-28 was promulgated by the Ohio Department of Insurance on June 18, 1976 to implement Amended House Bill No. 448. The purpose of this administrative rule is to ensure that hospital service associations make a good faith effort to control their own administrative costs as well as the costs charged to them by member health care facilities, pursuant to Section 1739.01 (L). Section 1739.01 (M) requires BCNWO's cost containment efforts to be "conscientious, vigorous, and continuing." In consideration of this statutory language we feel that BCNWO's progress in the cost containment area since the last hearing (February, 1977) is of major importance. The Report and Recommendation submitted to us, dated December 23, 1977 recommended that the 35.9% rate increase requested by BCNWO be reduced to 25%, because BCNWO was only partially in compliance with Rule 3901-1-28; this computes to a finding that BCNWO was approximately 70% in compliance with Rule 3901-1-28. After due and deliberate consideration of said Report and Recommendation, the record and exhibits it is our finding that BCNWO is not in compliance with Rule 3901-1-28, and on this issue we so modify said Report and Recommendation.

Section 119.09 requires the Department to state its reasons for modifying said Report and Recommendation. It is our finding that BCNWO is not in compliance with Section (F)(1)(b) of Rule 3901-1-28. The previous Report and Recommendation, dated March 11, 1977 emphasized BCNWO's inactivity since 1971 in reducing or eliminating excess beds; this Report and Recommendation was adopted by the Superintendent of Insurance by his Order dated March 30, 1977. The record makes it clear that BCNWO's inactivity in reducing the number of excess beds has continued since the previous public hearing in February, 1977. The closing of excess beds is a significant part of Section (F)(1)(b), and was admitted by BCNWO to be beneficial to the community and a saving of subscribers' money (Tr. 602,605).

The record clearly does not reflect a good faith effort by BCNWO to close excess hospital beds at any time. In particular, the record indicates that BCNWO has not made a good faith effort to close excess hospital beds since February, 1977, the date of the last hearing. For example, at the February, 1977 hearing BCNWO testified that Fremont Hospital had 36 OB beds; however, "We expect a 50% reduction come the next hearing . . ." (Tr. 990,982). The reduction of excess beds did not occur as of the most recent hearing (Tr. 991). In spite of this Fremont Hospital received a full rate increase from BCNWO on September 30, 1977 (Tr. 986). Wood County Memorial Hospital closed twenty excess beds; however, these beds were closed in 1974 (Tr. 704). There is no evidence that BCNWO was responsible for these bed closings, as the following testimony indicates: "We did not notify them that we wanted them closed. We *suggested* in discussion with the Administrator that the occupancy rate dictated that they consider closing a section of their hospital" (Emphasis added) (Tr. 705).

Twenty or twenty-five beds were built in 1973 or 1974 but have never been opened or staffed at Fulton County

Memorial Hospital (Tr. 692). No beds have been closed since February, 1977 (Tr. 639). Again it is difficult to credit BCNWO with assisting in keeping these beds closed. "'How did Blue Cross inform Fulton County Health Center that it wanted 20 beds closed?" "I don't think we dealt with them directly. It's education and persuasion. We dealt with them recognizing their financial condition and *suggested* that the beds be permanently closed until such time, and they agreed and honored that decision." (Emphasis added) (Tr. 637). On the same page BCNWO stated that their role was "education and persuasion." BCNWO did not use either financial incentives or financial disincentives to affect the excess bed situation at Fulton County Memorial Hospital (Tr. 704).

Bellevue Hospital closed ten beds more than a year ago, in November, 1976 (Tr. 676,685). Aside from the fact that this was even before the February, 1977 hearing, testimony indicates that BCNWO was not responsible for this closing. BCNWO did not use financial incentives or disincentives to affect this excess bed situation (Tr. 624,625); rather, BCNWO's involvement consisted merely of meetings "on several occasions" with the hospital's administrator, which BCNWO has characterized as education and persuasion (Tr. 680). In fact BCNWO testified this closing ". . . was a result of voluntary processes" (Tr. 680). There was conflicting testimony as to the number of beds closed at Fisher-Titus Hospital, the number being either twelve, fourteen or thirty-five (Tr. 617,671). In any event these beds were also closed before the February, 1977 hearing, in December, 1976 or January, 1977 (Tr. 685). Once again the record indicates that BCNWO was not responsible for these bed closings: "Turning to Fisher-Titus Hospital, how did Blue Cross inform Fisher-Titus that Blue Cross wanted them to close twelve excess beds?" "Well, I didn't make the statement that Blue Cross asked Fisher-Titus . . ." (Tr. 625). The statement ". . . we were

made aware that there were beds closed down . . ." (Tr. 626) indicates that BCNWO only learned of the closing after it had been accomplished and was therefore not a causative factor in this closing. Further testimony indicates that BCNWO was not responsible for this bed closing: "I think that the decision was made with input from Blue Cross. We did not meet with their Board of Trustees, as we quite often do . . ." (Tr. 626). As in all of the above-mentioned closings, BCNWO did not use specific financial incentives or financial disincentives to eliminate unnecessary beds at Fisher-Titus Hospital (Tr. 627,687).

The record indicates that two hospitals in Sandusky, Ohio (Good Samaritan Hospital and Providence Hospital) will consolidate their OB beds, for a net reduction of eighteen beds. BCNWO was unable to state with certainty the number, if any, of beds which had been closed since the February, 1977 hearing: "How many are closed right now?" "I cannot tell you the number today" (Tr. 709). BCNWO's testimony indicates that "The effective date of the consolidation will be January 1, 1978" (BCNWO Exhibit 1, Section IV, p. 6), which is after the hearing under discussion here. As in the previously mentioned excess bed situations BCNWO did not use financial incentives or disincentives to cause bed closings (Tr. 941). In fact testimony by BCNWO seems to indicate that it is not even taking credit for closing those eighteen beds (Tr. 940).

There is no testimony in the record that any excess beds have been closed down in BCNWO's service area between February, 1977 and the hearing under discussion here, i.e., the most recent hearing. Even considering the beds that have been closed down before the February, 1977 hearing, as discussed above, the record does not contain reliable, probative and substantial evidence that BCNWO was responsible for those bed closings, i.e., that BCNWO was a significant causative factor. BCNWO's hospital reimbursement contracts do not contain financial incentives or financial disincentives to cause hospitals to close excess beds (Tr. 631,632,634,635), in spite of the express language of Section 1739.01 (M).

There was extensive testimony about the number of excess beds in BCNWO's service area. Testimony at the May, 1976 hearing (p. 180) and at the February, 1977 hearing (pp. 265,267) indicates that BCNWO's service area contains approximately four hundred excess beds. This figure was incorporated in the Report and Recommendation, dated March 11, 1977 of the February, 1977 hearing, and therefore in the Superintendent's Order and Journal Entry dated March 30, 1977. This Order and Journal Entry was not appealed by BCNWO. BCNWO attempted, at the most recent hearing, to refute this figure; however, BCNWO did not suggest a correct or more accurate number. We would note that BCNWO identified eighteen excess beds in the Sandusky, Ohio area (BCNWO Exhibit 1, Section IV, p. 6). We agree with the Report and Recommendation dated December 22, 1977 that the number of excess beds that could be closed down resulting in a significant cost savings to BCNWO's subscribers was not satisfactorily addressed. However, the record indicates that BCNWO has not made a good faith effort to address this problem. As we stated above, BCNWO, while attempting to refute the four hundred excess bed figure, did not offer a more accurate number. Both Amended House Bill No. 448 and Ohio Department of Insurance Rule 3901-1-28 have been in effect since June 18, 1976. BCNWO's minimal activities in this area since that date do not constitute a good faith effort.

The closing of excess beds is perhaps the most significant aspect of Section (F)(1)(b). However, there are other important cost containment activities in this area which can be engaged in by hospital service associations. As of February, 1977 sixteen of BCNWO's twenty-seven contracting hospitals shared computer service to obtain

automated data processing capabilities. Testimony indicates that no new hospitals have joined this program, and that BCNWO has not used financial disincentives to promote it (Tr. 1083,1084,1085). One hospital has joined the shared management services program since the last hearing, for a total of six hospitals; however, BCNWO has not used financial disincentives to promote this program (Tr. 1085,1086,1087). The number of hospitals sharing EEG services has remained at two (Tr. 1087,1090). Testimony at the previous hearing indicated that two hospitals were attempting to share the services of their X-ray and maintenance departments. BCNWO was unable to document whether or not that program was successful (Tr. 1090). No new hospitals have joined an effort to share printing and security departments; the number remained at three hospitals (Tr. 1090). Although the attempt of two hospitals to share the services of a physical therapist, a dietician and a respiratory therapist was successful, no hospitals have been added to that program (Tr. 1092,1093,1094). Only one hospital has joined the shared oxygen purchasing program, for a total of eight hospitals (Tr. 1094,1095,1096). No hospitals have been added to the shared laundry program; the number remains at six (Tr. 1096,1097,1098). Some progress was indicated in the shared purchasing program (Tr. 1099); however, as in all of the above programs BCNWO did not promote their usage by specific financial disincentives (Tr. 1108). Although four hospitals have implemented a joint cooperative billing system (Tr. 1109), the record does not indicate that BCNWO was responsible for this (Tr. 1110, 1111). Again, BCNWO did not use specific financial disincentives to promote this program among hospitals. The record indicates that there has been no consolidation activity in the major radiation-cancer therapy program (Tr. 1119), or in the area of open heart surgery services (Tr. 1122).

Another activity under Section (F)(1)(b) is BCNWO's use of the cost containment grid (Tr. 1002). The Report

and Recommendation dated March 11, 1977 states that BCNWO should strive to establish a procedure which will result in reliable information being used in the cost containment grid. However, the record indicates that the cost containment grid, which serves as an index to each hospital's cost containment activities, has not been updated since the hearing in February, 1977 (Tr. 1005). In addition, testimony elicited from BCNWO on cross-examination indicates that BCNWO was not totally certain of the accuracy of the grid (Tr. 1011, 1012). No evidence was submitted by BCNWO relative to any procedure used by BCNWO to ensure the grid's accuracy. Although the number of hospitals availing themselves of shared technical services from the non-profit Clinical Engineering Center is ambiguous, no more than fourteen hospitals participate, as compared to the original thirteen hospitals in 1971. BCNWO has not used financial disincentives to encourage hospitals to use this service (Tr. 998,1114). It is our finding that BCNWO's activities do not constitute compliance with Section (F)(1)(b). BCNWO did not establish by reliable, probative and substantial evidence that it was making a good faith effort to comply with this section by using education, persuasion, financial incentives and financial disincentives.

With reference to Section (F)(6) of Rule 3901-1-28, it is our finding that BCNWO is not in compliance with this section. Testimony indicates the Admission by Individual Diagnosis (AID) program was used by twenty-two hospitals, the same number as in the May, 1976 and February, 1977 hearings (Tr. 1214). BCNWO provided no estimate of savings from this program. No hospitals have been added to the Coordinated Home Care program since February, 1977; the number of hospitals remains at nine. BCNWO does not use financial disincentives, either to encourage hospitals to join this program or to promote usage within the nine hospitals which have it (Tr. 1215,

1216,1221,1222). Although one facility has been added to the outpatient substance abuse program, BCNWO had not attempted to document the savings from this program (Tr. 1238,1239). BCNWO did not present any evidence of progress or savings in this program. Although BCNWO added one hospital to its outpatient physical therapy program, BCNWO offered no evidence of savings from this program. A program cannot be a viable alternative to inpatient care unless savings can be documented, both in number of inpatient days saved and subscribers' dollars saved. BCNWO has not used financial disincentives to promote usage of this program in the facilities which participate; neither did BCNWO attempt to document this program's savings (Tr. 1247,1248).

No new skilled nursing facilities have been contracted with (Tr. 1256). BCNWO offered no evidence of this program's savings (Tr. 1251). The Verticare program, as in February, 1977 is not yet operational and has resulted in no savings (Tr. 1266, 1267, 1268). No financial disincentives are used to promote this program (Tr. 1271). BCNWO was unable to estimate savings from post-discharge testing programs (Tr. 1276,1277). BCNWO testified that the PDT program was being absorbed by the Verticare program (Tr. 1274); however, the Verticare program is not operational (Tr. 1266, 1267, 1268). BCNWO has not been active in promoting an HMO as an alternative to inpatient care (Tr. 1279). BCNWO has not yet contracted with any ambulatory surgical facilities (Tr. 1284,1285). BCNWO has added two hospitals to the Pre-Admission Testing program; however, no financial disincentives are used to promote usage of PAT within these hospitals (Tr. 1211).

It is our finding that BCNWO's activities in promoting alternative forms of care do not constitute a good faith effort pursuant to Section (F)(6). As indicated above BCNWO did not establish by reliable, probative and substantial evidence that it is promoting alternative forms of care by the use of education, persuasion, financial incentives and financial disincentives. In addition the savings of many programs were not documented. Amended House Bill No. 448 and Rule 3901-1-28 have been in effect approximately eighteen months; in view of this, BCNWO's activities in this area are not sufficient to constitute compliance with Section (F)(6).

It is my finding that BCNWO is not in compliance with Section (F)(7) of Rule 3901-1-28. Implementation of the Joint Profile System (JPS) would be an essential part of compliance with Section (F)(7). The JPS is a computerized, retrospective utilization review system. It allows hospital service associations that have JPS to compile statistical data as to type of patient and type of illness. This allows the development of admission criteria and assists in establishing statistical norms. Testimony indicates that at present all hospitals do not perform retrospective utilization review on all patients (Tr. 1326); JPS will allow such review on all patients. BCNWO does not use financial disincentives to promote retrospective utilization review on all patients (Tr. 1327).

The implementation of JPS in 1977 was mentioned by BCNWO in February, 1977 as a corporate goal. As of the most recent hearing JPS still had not been implemented by BCNWO. In fact, testimony indicates that it will not be implemented until January 1, 1978: "We will be on it January 1st. We are in preparation for it, sir" (Tr. 371, 375,55). In essence BCNWO was at the developmental stage with JPS as of the most recent hearing, just as it was in February, 1977. This indicates that a good faith effort in this area was not made by BCNWO, in view of the fact that Amended House Bill No. 448 and Rule 3901-1-28 have both been in effect approximately eighteen months. We must note that two other hospital service associations in this state have JPS (Tr. 390).

Page 737 of the February, 1977 transcript indicated that, with reference to JPS, BCNWO was implementing a new inpatient billing system to be in operation by September or October, 1977. The JPS was to follow this. However, testimony indicates that rather than September or October, 1977, this new billing system would not be implemented until January 1, 1978 (Tr. 1074).

Testimony at the February, 1977 hearing indicated that BCNWO was studying three alternatives relative to selection of a uniform data base. As of the most recent hearing BCNWO was still studying all of the alternatives and had not yet selected one, as the following testimony indicates: "None of the options have been chosen at this point . . ." "We've progressed up to the point where we are ready to begin trying to select an alternative . . ." (Tr. 394). Therefore this project is essentially at the same stage as in February, 1977.

Section (F)(7) requires in part, engagement in *and* evaluation of incentive reimbursement (Tr. 1340). The record is clear that BCNWO has evaluated incentive reimbursement programs; however, it is also clear that BCNWO has not "engaged in" incentive reimbursement. BCNWO will begin a pilot enhanced incentive reimbursement program with one hospital as a cost control experiment, on January 1, 1978 (Tr. 1332). "That's when the actual reimbursement would begin to reward that hospital for cost containment activities?" "Right" (Tr. 1334,1335). We must note that as of the most recent hearing BCNWO was not actually engaging in enhanced incentive reimbursement, as a cost containment experiment, with this or any hospital. Therefore, eighteen months after the effective date of Amended House Bill No. 448 and Rule 3901-1-28, BCNWO still was not "engaging in" incentive reimbursement as a cost containment experiment required by Section (F)(7). BCNWO's activity in this area was virtually at the same point as in February, 1977. The Report and

Recommendation dated March 11, 1977 which was adopted by the Superintendent in his Order and Journal Entry dated March 30, 1977, stated that BCNWO would be expected to make great progress in this area by the next hearing. The record does not reflect substantial progress in this area.

It is my finding that BCNWO has not proven by reliable probative and substantial evidence that it has made a good faith effort in the cost containment areas defined in Section (F)(7).

As Superintendent of Insurance we are of course concerned with the solvency of all insurers in this state. We must note that BCNWO's months of reserves will increase from approximately 1.7 months as of December 31, 1977 to approximately 2.0 months as of December 31, 1878, even if the rate increase requested on October 14, 1977 is denied (Tr. 756,757,758). We must also take cognizance of the fact that on March 30, 1977 we approved, in part, a rate increase requested by BCNWO. This rate increase was effectuated as recently as May 1, 1977, June 1, 1977 and July 1, 1977 (Tr. 761).

It is our finding, as indicated above, that BCNWO is not in compliance with Sections (F)(1)(b), (F)(6) and (F)(7) of Ohio Department of Insurance Rule 3901-1-28. These three sections represent extremely significant cost containment objectives as defined by Rule 3901-1-28. In addition the record indicates that BCNWO has not made a good faith effort in the use of education, persuasion, financial incentives and financial disincentives to promote sound management practices in member health care facilities (Tr. 1045,1046,1047,1050,1065,1132,1140,1144,1150). This relates to Section (F)(4) of the Rule. BCNWO has not made substantial progress in this area. For the above reasons it is our finding that BCNWO has not shown by reliable, probative and substantial evidence, as required by Section 1739.051, that it has made a good faith effort in the area

of cost containment as defined by Section 1739.01 and Rule 3901-1-28. Ohio's health care consumers are entitled to more progress in the cost containment area than is indicated in the record. We must repeat that BCNWO's cost containment efforts must be "conscientious, continuous, and vigorous," pursuant to Section 1739.01 (M). Because it is my finding that BCNWO is not in compliance with Rule 3901-1-28, the requested rate increases filed by BCNWO with the Ohio Department of Insurance on October 14, 1977 are not lawful, fair and reasonable pursuant to Section 1739.01 (L). THEREFORE, IT IS HEREBY ORDERED that the proposed rate increases filed by BCNWO with the Ohio Department of Insurance on October 14, 1977 be and hereby are denied.

/s/ HARRY V. JUMP
Harry V. Jump
SUPERINTENDENT OF INSURANCE

Dated: January 6, 1978.

CERTIFICATE OF SERVICE

I hereby certify that on January 6, 1978 I sent copies of the above Order and Journal Entry to Mr. Dennis E. McClung, President, Blue Cross of Northwest Ohio, P. O. Box 943, Toledo, Ohio 43655 by certified mail number 111095, and to Mr. James P. Kennedy, Esq., Vorys, Sater, Seymour and Pease, 52 East Gay Street, Columbus, Ohio 43215 by certified mail number 111096.

/s/ JAMES F. MOSIER
James F. Mosier
ASSISTANT DIRECTOR
OHIO DEPARTMENT OF INSURANCE

REPORT AND RECOMMENDATION OF THE HEARING OFFICER

IN THE MATTER OF THE APPLICATION OF BLUE CROSS OF NORTHWEST OHIO, TO INCREASE RATES CHARGED NON-GROUP SUBSCRIBERS

On October 14, 1977 Blue Cross of Northwest Ohio (hereinafter referred to as BCNWO) with its principal office in Toledo, Ohio filed a request for a rate increase on its non-group subscribers to be effective March 1, 1978. These subscribers are those who pay their premiums directly to Blue Cross rather than through a group mechanism.

The contracts involved and the current and proposed monthly rates are:

Non-Group Medicare Complementary

	Current Rates	Proposed Rates
$124 Deductible	$4.65	——
$144 Deductible (1/1/78)	——	$6.00

Non-Group Under 65 Years of Age

	Current Rates		Proposed Rates	
70 Day 80/20	Single	Family	Single	Family
Bank	$23.90	$45.45	$34.05	$67.80
Direct Pay	$25.20	$49.80	$35.85	$71.35
70 Day Comprehensive				
Bank	$27.70	$52.55	$36.60	$72.90
Direct Pay	$29.15	$57.55	$38.55	$76.75

BCNWO will also offer new subscribers with effective dates on or after March 1, 1978 a choice between a High Option of 120 days Comprehensive and or Low Option of 120 days 80/20 both with Outpatient Diagnostic benefits. Existing contract holders are to be given the choice of retaining the coverage now in force or converting to

either of the two new options. Effective date of such conversions will be June 1, 1978.

High Option-120 Day Comprehensive—Proposed Rates

	Single	Family
Bank	$38.35	$76.50
Direct Pay	$40.30	$80.40

Low Option-120 Day 80/20 Proposed Rates

	Single	Family
Bank	$31.15	$62.10
Direct Pay	$32.70	$65.30

The proposed combined non-group increase in premiums for the Bank/Direct Pay Subscribers and the Medicare Complementary Subscribers is 35.9% of annual income at current rates. The proposed rates for the new High Option and Low Option plans, of course, do not involve increases.

Section 1739.051 Ohio Revised Code provises that no Hospital Service Association can issue or amend any subscriber contract or change the rates charged for a subscriber contract, which is not rated by a group rating experience formula, unless the Superintendent of Insurance determines the new rates to be "lawful, fair and reasonable," and that such Association show "by reliable, probative, and substantial evidence that the association is exerting a good faith effort to control costs." Pursuant to Section 1739.051 Ohio Revised Code a public hearing was held on November 29, 30 and December 1 and 2, 1977 in Toledo, Ohio to take evidence bearing on this determination. The following discussion of the evidence adduced at the hearing will first deal with the actuarial justification for the rate increase on the non-group under 65 contracts, the Medicare Complementary contracts and the rates for the new High Option and Low Option contracts and then will deal with the cost containment efforts of

BCNWO; this will follow the order of the sections in Insurance Department Rule IN-1739.02.

Actuarial Justification for Increase

The basic principle of rate making is that the premium charged should produce sufficient funds to pay all expected claims and expenses of the group covered plus a factor for additions to reserves that may be needed for unexpected claims or expenses. The October 14th filing of BCNWO, the testimony and exhibits (Thieman testimony and exhibits) describe the actuarial methodology used in computing the proposed rate increases and the rates for the two new options to be offered. The testimony and exhibits demonstrate that BCNWO sustained an underwriting loss on its non-group business of $3,816,283.71 for the period of July, 1976 through June, 1977 (Thieman Exhibit 7). It appears certain that the losses on this class of business will continue and probably will increase because of the continuing increase in the cost of hospital care unless a rate increase is approved. Cross-examination by the Insurance Department did not controvert either the actuarial calculation used or the demonstrated need for the rate increase requested. I therefore find that BCNWO has justified the need for the increase applied for and that their filing is in accordance with sound actuarial principles.

Before recommending that the full increases applied for be approved, it is necessary to review the cost containment efforts being used by BCNWO to determine if they meet the "good faith effort" to control both BCNWO administrative costs and the costs charged to it by health care facilities as required by the legislation adopted last year (Amended House Bill 448) by the Ohio General Assembly. The standards which must be met appear in Sections 1739.01 and 1739.051 Ohio Revised Code and Rule 3901-1-28. A "good faith effort" is defined in the law to mean: "A conscientious, vigorous, and continuing attempt by a hos-

pital service association through a combination of education, persuasion, and financial incentives and disincentives to control costs and encourage member health care facilities to control costs by accomplishing the following objectives . . ." There follow seven specific objectives and the authority for the adoption of other cost containment policies by the Superintendent of Insurance. Standards such as "good faith effort", "conscientious", "vigorous" and "continuing attempt" are not subject to precise mathematical calculation but require instead a judgment by the Superintendent of Insurance as to the degree to which such standards have been met and if they have not been fully met the effect such a lack can be permitted to have on the demonstrated need for the rate increase applied for.

As I have indicated discussion of the cost containment activities of BCNWO will follow the order in which these activities are dealt with in Rule 3901-1-28.

Reporting Requirements

Section (C)(1) provides as follows:

> "In conjunction with any filing for a rate increase or amendment to a rating formula pursuant to Section 1739.051 of the Ohio Revised Code, a Plan shall provide to the Superintendent a report on its efforts to comply with Sections (F) and (G) of this Rule. This report shall include both a narrative description and appropriate statistical indicators as required by the Superintendent of Insurance."

On October 14, 1977 BCNWO filed with the Superintendent of Insurance a request for his approval of proposed rate increases for several classes of business in the non-group category and the establishment of rates for two new contracts described as "High Option" and "Low Option" contracts to be offered non-group subscribers next spring. (B.C. exhibit 1) Attached to the request was an

actuarial demonstration of the need for the proposed rates. Also attached was a narrative description of BCNWO efforts to comply with the Rule. The Insurance Department objected to the exhibit because it charged that it contained some inadvertent inaccuracies and misleading statements. It was ruled that acceptance of the exhibit did not foreclose an attack on some of its contents; it was therefore admitted. I therefore find that the BCNWO filing meets the reporting requirements of (C)(1) of the Rule.

Section (C)(2) provides as follows:

> "Every Plan shall make a good faith effort to cooperate with other Plans to develop common procedures and definitions so that the narrative and statistical data provided under subsection (C)(1) is comparable among the Plans."

BCNWO represented in its prefiling and testimony that it has actively participated in efforts of all Ohio Plans to develop uniform systems and approaches to many areas of Blue Cross activity. The Uniform Chart of Accounts designed to promote uniform financial reporting is now being used by all Ohio Plans as is the Statewide Prescription Drug Program. The Standard National Accounting Program is being used by all the Ohio Plans except the Cleveland Plan. None of these are new developments since the last rate hearing for BCNWO. At the last rate hearing BCNWO indicated that it was considering the implementation of the Joint Profile System, a system of reporting hospital care statistics in order to study the impact of any of the various factors that make up the total cost of care. At this hearing the program has been implemented, the software is in place and the system is to begin to function on January 1, 1978. BCNWO has had the cooperation and assistance of Blue Cross of Central Ohio in installing this system and Blue Cross Association is orga-

nizing an Ohio J.P.S. Users Group to which BCNWO has appointed three members and in which it will actively participate. Testimony also indicated that BCNWO was also participating in statewide Task Forces studying: common underwriting policies; simplification of claims handling and a teleprocessing system for handling all Ohio Medical Indemnity cases. Additionally all of the Ohio Plans are participating in the development of standard provider criteria for contracting with new classes of providers such as substance abuse centers, free standing outpatient physical therapy centers and outpatient psychiatric programs. Cross-examination pointed out that there had been study but very little action in the areas of statewide group and conversion rating formulas, statewide underwriting regulations, a uniform data base system and the B.C.A. Long Range System Program. In spite of this I find that BCNWO has engaged in a continuing program of cooperation with other Plans to develop common procedures and definitions for reporting information. I therefore find it in substantial compliance with this subsection of the Rule. It is expected that at the next hearing the Insurance Department will pursue its inquiry into the areas where cross-examination disclosed some study but no significant progress.

Section (C)(3) provides as follows:

> "Every Plan shall include in its annual report filed pursuant to Section 1739.09 of the Ohio Revised Code an itemized account explaining how its annual dues to the Blue Cross Association have been expended."

The Plan submitted the itemized account prepared by B.C.A. explaining how BCNWO annual dues to B.C.A. have been expended. Cross-examination pointed out that there were other special charges made by B.C.A. that were not characterized as "dues"; however it was held that the B.C.A. account of its "annual dues" was sufficient to meet the requirement of the Rule. Consequently the Plan is in

compliance with this subsection of the Rule. Under cross-examination testimony was also elicited concerning how B.C.A. activities contributed to the cost containment programs of BCNWO.

Section (C)(4)(a) provides as follows:

> "Submit to the Superintendent a statement which describes its subscriber grievance mechanism for the expeditious resolution of written complaints initiated by subscribers concerning any matter relating to any provision of the Plan's subscriber contracts including, but not limited to, claims regarding the scope of coverage for health care services and denials, cancellations or nonrenewals of enrollee coverage."

BCNWO attachment 2 in its Exhibit 1 complies with this requirement. Since the last hearing notice of this grievance mechanism has been given to all non-group subscribers. A copy of the procedure has not been so furnished. There was some discussion of the desirability of including this procedure in individual contracts when such contracts are next rewritten by the Plan. I find BCNWO in compliance with this subsection of the Rule.

Section (C)(4)(b) provides as follows:

> "Maintain for examination by the Superintendent a summary record of the complaints filed under the Plan's grievance mechanism and the disposition of each such complaint."

BCNWO does maintain for examination by the Superintendent a summary record of complaints filed under its grievance mechanism and the disposition of each such complaint. BCNWO exhibit 9 is a copy of that log covering the period January 3, 1977 through November 15, 1977. I find the Plan in compliance with this subsection of the Rule.

Reserves

Section (D)(1) provides as follows:

> "An unassigned surplus of not greater than three (3) months' estimated claims and operating expenses shall be deemed sufficient for all Plans. The Superintendent may give written authorization to a Plan involved in either promoting alternative forms of care or in conducting cost-control activities pursuant to Section (G) to retain additional unassigned surplus."

BCNWO testimony showed that its reserves stood at 1.17 months at the end of 1976 and that as of August 31, 1977 the latest date for which figures were available, the reserves equalled 1.31 months estimated claims and operating expenses. This is well within the maximum of 3 months in the Rule and therefore BCNWO is in compliance with this subsection of the Rule. Other testimony relating to reserves bear directly on the need for the rate increase being requested. If the rate increase is not granted it will have a negative impact on the reserve equal to a reduction of one half month (Record p.245). The historical non-group experience of BCNWO shows an underwriting loss every year beginning with 1971 (Record p.p. 250-251). These were 1971 $351,000.00; 1972 $619,000.00; 1973 $1,112,000.00; 1974 $1,902,000.00; 1975 $4,735,000.00; 1976 $4,903,000.00; the first seven months of 1977 $2,128,000.00; total 1971 through July 31, 1977 $15,749,000.00. The financial requirement of the national Blue Cross Association is a minimum of three months of expenses (Record p. 282). The low level of the reserves of BCNWO has caused B.C.A. to place BCNWO on a probationary status (Record p.p. 283 and 502-204). The reserve level corporate objective of BCNWO is to reach two and a half to three months of expenses in reserve (Record p. 262). The projections proposed by BCNWO show that if the rate increase requested is approved the number of months of reserve at the end of the rating period would be 1.6 to 1.71 months. (Record p.

245) On cross-examination the testimony was that if the full increase is approved the reserve at the end of 1978 would be 2.4 months, if 50% of the increase is approved 2.2 months and if no increase is approved 2 months. (Record p.p. 756-757). There was also testimony showing that the group contracts of BCNWO included a 2% factor for addition to all reserves (including the non-group reserves) so that to this extent the group business was subsidizing the non-group reserves.

Section (D)(2) provides as follows:

> "When for a period of six (6) consecutive months, a Plan's unassigned surplus exceeds the maximum established pursuant to subsection (D)(1), the Plan shall use such funds to effect one or more of the following measures: (a) provide premium credits to appropriate accounts; (b) eliminate the risk factor from appropriate accounts; (c) provide premium credits to the accounts of all direct pay subscribers; (d) expand benefits to appropriate accounts of all subscribers; and (e) any other appropriate measures to accomplish the same objectives which receive the written approval of the Superintendent."

This subsection is not applicable to BCNWO because its unassigned surplus (reserves) are less than the maximum established in Section (D)(1) above.

Open Enrollment

Section (E)(1) provides as follows:

> "Every Plan shall have an annual open enrollment period of at least thirty (30) days for persons who wish to enroll as direct-pay subscribers. The Plan may impose regulations regarding open enrollment designed to prevent duplicate coverage as well as such underwriting restrictions as are necessary to preserve

its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for subscriber coverage of health care services. Such reasonable underwriting restrictions may include health statements, limits on the coverage of pre-existing conditions and probationary periods."

BCNWO had an annual open enrollment period from May 1, 1977 through May 31, 1977 (Record p. 524). It is therefore in compliance with this section of the Rule.

Section (E)(2) provides as follows:

"In lieu of an annual enrollment period of at least thirty (30) days, a Plan may have continuous open enrollment for persons who wish to enroll as direct-pay subscribers. The Plan may impose regulations regarding open enrollment designed to prevent duplicate coverage as well as such underwriting restrictions as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for subscriber coverage by health care services. Such reasonable underwriting restrictions may include health statements, limits on the coverage of pre-existing conditions and probationary periods."

BCNWO plans to have an open enrollment period of either a thirty-one day period during the calendar year 1978 or to consider continuous enrollment as an alternative, the decision not having yet been made by the Board of Directors of BCNWO. Under cross-examination there was discussion as to whether the term "annual" in the Rule referred to a twelve month period or a calendar year period (Record p.p. 525-527). BCNWO stated that with regard to its 1978 enrollment period it would comply with the Departments interpretation of the Rule. For the guidance of B.C. in the future it is my recommendation that the term "annual" as used in this subsection be interpreted to mean once each calendar year.

This subsection of the Rule has no current application to BCNWO.

Rate Review

Section (F)(1) provides as follows:

"Elimination of duplicative or unnecessary services and facilities by:"

Section (F)(1)(a) provides as follows:

"Refusing to reimburse member health care facilities for any expenses related to a capital expenditure whenever federal reimbursement has been denied for such capital expenditure and consistent with the policy and procedures manual and operating plan of the Ohio Department of Health, the state designated planning agency. This measure shall be effected through the Plan's contract with member health care facilities or by such other means as are approved by the Superintendent."

BCNWO attachment #10 submitted with its prefiling is an amendment of its Inter Hospital Agency Contract. This amendment was approved by the Board of Directors of BCNWO and is included in all of the contracts of the twenty seven hospitals in BCNWO. (Record p.p. 75-76 and 530-542). With respect to health care facilities other than hospitals, BCNWO has included in its facility contracts a provision which permits reimbursement only after the facility has received approval from the appropriate health systems agency (Record p. 76). I find the BCNWO is in compliance with this subsection of the Rule.

Section (F)(1)(b) provides as follows:

> "Making a good faith effort to have member hospitals consolidate, share, convert or phase out inappropriate or unnecessary services or facilities under criteria developed by the appropriate planning agencies, and consistent with the State Plan for Health Facilities of the Ohio Department of Health issued pursuant to Section 3701.39 of the Ohio Revised Code."

There was much testimony under both direct and cross-examination concerning the delay in the development of criteria by "the appropriate planning agency" to evaluate the services or facilities used by member facilities. The development of such criteria must begin with the federal government, then come to the state government and finally to the local Health Planning Agency. BCNWO has actively participated at the local level. The responsibility for the current lack of criteria is that of the federal government agency and under a strict interpretation of this Rule BCNWO would be considered to be in compliance; however, such an interpretation would be in conflict with the primary thrust of the law which is to put responsibility on a hospital service association for a good faith effort to control costs charged to it by health care facilities, including hospitals. "Good faith effort" means "a conscientious, vigorous and continuing attempt by a hospital service association through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage member health care facilities to control costs by accomplishing the following objectives: (1) Elimination of duplicative or unnecessary services and facilities; . . ." The failure of the federal government in the development of criteria to guide local efforts to eliminate duplicative or unnecessary services and facilities is understandable but cannot be accepted as an excuse to delay efforts to comply with the broad purpose of the law. In this case BCNWO did not use the federal delay as

such an excuse but simply to explain how much more difficult it made efforts of BCNWO to force member health care providers to close unneeded beds or eliminate other unnecessary services or facilities. BCNWO has made a substantial start in this area and for this is to be commended. Cited examples of BCNWO activity were BCNWO participation in negotiation leading to the closing of some unneeded beds in several member hospitals; successful opposition to a proposal which would have added 90 additional beds in one member hospital (Record p.p. 77-78); opposition to the expansion of additional beds in a second hospital where a financial disincentive was employed (Record p. 79); the consolidation of the operations of two Sandusky hospitals, consolidating obstetrical beds and services in one and pediatric beds and services in the other (Record p.p. 82-83) resulting in an 18 bed reduction; BCNWO support for a non-profit organization in Toledo which offers hospitals a means of sharing certain services (Record p.p. 84-86), BCNWO announced it would allow such services as reimbursable expenses; and BCNWO support for shared laundry service and shared purchasing (Record p. 87); and BCNWO active participation in the planning processes affecting all health care facilities in its area. In spite of this activity much remains to be done in this area of cost containment.

In cross-examination much attention was given the charge in the Hearing Officer report of the last rate hearing that 400 excess beds existed at the time of that hearing. In reply BCNWO witnesses pointed out that this figure dealt with the number of State certified registered beds as opposed to those actually staffed and in use. (Record p.p 598, 663-676). For example a hospital could destaff and close down a whole wing but this would not reduce the certified beds for which it was accredited. It was also explained that the final decision to close or not to close beds was made by the local hospital authorities and not

controlled by BCNWO. The number of excess beds that could be closed down resulting in a significant cost savings was not satisfactorily addressed. It is hoped that criteria to make such judgment will be available before the next rate hearing but in any event BCNWO should address itself to this problem and be prepared to respond fully to inquiries relating to it.

I find that BCNWO has made a substantial beginning in this area of cost containment but is still in only partial compliance with subsection (F)(1)(b) of the Rule.

Section (F)(2)(a) provides as follows:

> "Developing and issuing bylaws that clearly and plainly define financial and institutional conflicts regarding a Plan's board of trustees."

BCNWO introduced copies of its by-laws (Record p. 58-59) (BCNWO Exhibit 1 attachment #3) and the conflict of interest questionnaire (BCNWO Exhibit 1 attachment #4). I find the Plan in compliance with this subsection of the Rule.

Section (F)(2)(b) provides as follows:

> "Assuring that every Plan committee dealing with relationships with subscribers and health care facilities, including but not limited to its executive committee, rate review committee, and its nominating committee but not including professional advisory committees (e.g., medical advisory committee, hospital advisory committee) be reflective of the non-provider majority on the Plan's Board of Trustees."

Testimony by BCNWO was that all committees of the Board have a two-thirds non-provider majority (Record p.p. 59-60, BCNWO Exhibit 1 attachment #5). I find that the Plan is in compliance with this subsection of the Rule.

Section (F)(3)(a) provides as follows:

> "Giving each subscriber timely notification of his right to obtain an itemized bill. Each Plan shall make a good faith effort to see that a subscriber receiving inpatient care is given an itemized bill on his request."

Testimony was that all member hospitals now furnish an itemized bill on request and that all BCNWO subscribers have been notified of their right to receive an itemized bill. (Record p.p. 88-90) BCNWO is in compliance with this subsection of the Rule.

Section (F)(3)(b) provides as follows:

> "Developing educational programs designed to encourage subscriber support of cost containment efforts."

BCNWO thru testimony, exhibits and radio and television demonstrations presented a very active educational program relating to its cost containment efforts. Very little of it was directed to its subscribers. One news publication "News Capsule" is directed at BCNWO's subscribers under age 65 and is intended to be published quarterly. This first issue carried some cost containment articles. None of the other BCNWO are furnished to non-group subscribers although they do have cost containment messages. Instead they go: "Digest-Digest" to sixty management members and two hundred ten other persons outside the plan; "Perspective" magazine to 2,000 selected readers; BCNWO "Annual Report" to trustees, legislators, group leaders, health groups, labor leaders and news media; "Northwestern" is the house organ for its employees; a desk calendar that goes to 6,200 group subscribers and is intended primarily as a PR sales tool; and distribution of seven health care articles published by the Blue Cross Association with no distribution to the non-group subscribers as such.

BCNWO also outlined its cost containment activities through a speakers bureau; advertising in newspapers, magazines, radio and television all of which are commendable but are not directed to its non-group subscribers. The establishment of four Member Advisory Committees representing four geographical areas was announced, it remains to be seen how non-group subscribers will be represented in this new activity. Under the heading "Collateral Material" BCNWO: (1) through letters and folders sent to both group and non-group subscribers BCNWO has promoted the sale of a book "Take Care of Yourself; A Consumer Guide to Medical Care" at a greatly reduced price when bought through BCNWO; the Pre-Admission Testing program is advertised through advertising, posters and calendars; audio-visual programs promoting alternate delivery systems are presented for doctors, nursing staffs and the general public; posters have been prepared for group policy holders and to be placed in doctors offices.

With the exception of the new publication "News Capsule" none of these activities, admirable though they may be, are directed at the non-group subscribers and most of them are not directed at any subscribers except as they are members of the general public. I therefore find that BCNWO is only in partial compliance with this subsection of the Rule which requires a good faith effort to encourage subscriber support of cost containment activities.

Section (F)(4) provides as follows:

> "Promotion of sound management practices in member health care facilities by:"

Section (F)(4)(a) provides as follows:

> "Making a good faith effort to encourage member health care facilities to develop purchasing policies to assure prudent buyer practices."

BCNWO testimony was that its staff reviewed the purchasing practices of member hospitals as a function of its audit and through the completion of an internal control questionnaire. The information thus produced reflect the methods used to assure prudent buyer practices. BCNWO continually urges purchasing policies that minimize costs such as bulk purchases cash discounts, competitive bidding, etc. (Record p.p. 90-93) I find BCNWO in compliance with this subsection of the Rule.

Section (F)(4)(b) provides as follows:

> "Making a good faith effort to have member health care facilities establish a bad debt control program as a precondition to Plan reimbursement for the member health care facilities' bad debts. Such a program shall include but need not be limited to, compliance with standard criteria by type of health care facility and patient mix developed by the Plan and containing as a minimum, the following elements: (1) data collection, including age of accounts receivable by the type of payment mechanism; (2) financial counseling; (3) classification of charity patients; and (4) collection procedures."

BCNWO requires each of its members to have an established and effective bad debt program. Its contract with its members limits bad debt losses to a maximum of 3% of the net inpatient income. The bad debt program is monitored as a function of the annual audit. (Record p.p. 93-94) I find BCNWO in substantial compliance with this subsection of the Rule; however, I feel that BCNWO could profitably devote more attention to its facilities bad debts even though the total did not exceed the maximum in their contracts.

Section (F)(4)(c) provides as follows:

> "Making a good faith effort to have member health care facilities establish, maintain and utilize appropriate financial and statistical information systems."

BCNWO requires that all member hospitals file annual statements of reimbursable costs (a uniform cost report) based on the American Hospital Association Chart of Accounts. (Record p. 94) Twenty-two hospitals use the Hospital Administrative Services, twenty-six use public accounting firms, twenty-two participate in P.A.S. (Professional Activities Statistic) eleven in the Ohio Hospital Management Services and twenty-six use two or more of these services (BCNWO Exhibit #1, p. 12). BCNWO has purchased and installed the Joint Profile System developed by Blue Cross and Blue Shield associations. This used standard hospital claims data made available through uniform billings to generate utilization statistics and profiles (Record p.p. 97-101). No reference was made in testimony to the further development of the Post Utilization Review System testified at the rate hearing of February, 1977. I find that BCNWO is making a good faith effort in the area of its activity and is in compliance with this subsection of the Rule.

Section (F)(4)(d) provides as follows:

> "Making a good faith effort to have member health care facilities employ management techniques such as industrial engineering."

BCNWO testified that there are now eleven hospitals participating in the Ohio Management Services Program (OHMS) and that BCNWO contributed $7,800.00 in support of OHMS development of new programs. An additional six hospitals have their own industrial engineering staff (Record p. 162). Seven other hospitals are too small to afford industrial engineering. For these BCNWO is continuing to study the feasibility of joining two or more of them for this industrial engineering function. Other effective hospital management techniques promoted by BCNWO are C.P.A. management reports, such as feasibility studies and long range planning programs (Record p.

105). I find that BCNWO is making a good faith effort in this area and is in compliance with this subsection of the Rule. This area of cost savings can be quite productive and I urge BCNWO to actively pursue and enlarge upon its activity.

Section (F)(5) provides as follows:

> "Implementation of sound Plan management practices by:"

Section (F)(5)(a) provides as follows:

> "Developing coordination-of-benefits and subrogation policies."

BCNWO testified that since the last rate hearing all non-group certificates contain a Coordination of Benefits Clause (COB) (Record p. 38 and p. 60) and all for some time have had the subrogation provision (Record p. 60). I find BCNWO in compliance with this subsection of the Rule.

Section (F)(5)(b) provides as follows:

> "Cooperating with other Plans through the sharing or consolidation of administrative services at an inter-Plan level to improve cost effectiveness and quality of service."

BCNWO testified as to its cooperation with other Plans through its participation in the work of statewide committees such as: Plan Presidents, Steering (Record p. 61), and Drug; statewide task forces dealing with: underwriting, data processing, ERISA, uniform billing, marketing, grievance procedures; a special Tol/Col steering committee to share combined expertise and equipment of the Toledo and Columbus plans; BCA programs; processing of Federal Employee Program supplementary claims and Medicare reconsiderations of B.C. of Southwest Ohio; and BCNWO processes major medical claims for O.M.I. (BCNWO Exhibit #1 p. 13).

I find BCNWO in compliance with this subsection of the Rule and urge a continuation and enlargement of these important cost savings programs.

Section (F)(6) provides as follows:

> "Promotion of alternative forms of care by making a good faith effort to have health care facilities develop alternatives to inpatient care such as outpatient hospital services, ambulatory health facilities as defined in Section 1739.01 (K) of the Ohio Revised Code, home health care services and skilled nursing facility services."

BCNWO testified to the following alternate forms of health care together with the estimated annual savings for the use of each form of alternate care over the cost of such care as an inpatient in a hospital:

(a) Pre-Admission testing: all twenty seven hospitals participate. In July, 1977 BCNWO began a special monitoring system with each hospital to document their participation in the program. Estimated annual savings $395,000.00 (Record p.p. 108-110).

(b) Coordinated Home Care: the nine Toledo hospitals (the same number as at the last rate hearing) are participating, the most recent efforts have been to present the program to four additional hospitals and two home health agencies, estimated annual savings $350,000.00 (Record p.p. 111-112)

(c) Free Standing Substance Abuse Facilities: BCNWO has contacted fourteen such providers—only four have demonstrated potential ability to contract with BCNWO. A new contract covering these services has been approved by the State Insurance Department. Additional criteria requires health planning approval and proper clinical staffing. The interested facilities are attempting to comply. It is expected that contracts will be signed with several facilities in December 1977. (Record p.p. 112-114)

(d) Outpatient Physical Therapy Providers: Twenty-Seven hospitals, and four skilled nursing facilities (one hospital more than last year) participate. In addition BCNWO has signed a contract with one free-standing outpatient physical therapy provider and is negotiating with another. BCNWO finds little difference in the cost of physical therapy in a free standing setting, as compared to a hospital outpatient department. (Record p.p. 114-115)

(e) Outpatient Psychiatric Care Program: BCNWO has contracts with twenty-one outpatient psychiatric care facilities (the same number as last year). Estimated savings $303,000.00 (Record p.p. 116-117)

(f) Verticare Program: A copyrighted program of BCSO designed to treat health problems while the patient is "vertical" and on his feet rather than "horizontal" in an expensive hospital bed. BCNWO has received permission from BCSO to utilize the Verticare program. BCNWO has reached agreement with two hospitals to begin Verticare programs in December 1977 and will add others as more agreements are reached. (Record p.p. 119)

(g) Occupational Therapy Pilot Program: BCNWO has begun a twelve month hospital pilot program to administratively provide coverage for occupational therapy (functional) when it is rendered in conjunction with a phychiatric admission. Four hospitals have agreed to participate. This is

classified as a "reduced stay" program. Estimated annual savings $1,717,000. (Record p.p. 119-120)

(h) Home Hemophilia Program (Alternate Delivery System). Only one of the eight approved hemophilia centers in Ohio is in the BCNWO area, it is at Toledo Hospital. To keep informed about changes in the program BCNWO has joined the Northwest Ohio Hemophilia Foundation. By having the hemophiliac treated at home rather than in a hospital it is estimated the annual savings will be $38,000.00. (Record p.p. 120-122) Last year the estimated savings covering eight patients was $80,000.00.

(i) Outpatient Hospital Services: All BCNWO contracts cover the following outpatient hospital services: emergency care within seventy-two hours of an accident, outpatient surgery, reduction of dislocations and fractures, shock therapy and blood transfusion. In 1975 approximately eighty-eight per cent of BCNWO contracts also had the outpatient diagnostic rider. (Record p. 122) The Hearing Officer Report of March 11, 1977 pointed out that this rider was not offered on individual contracts and recommended that the Plan should study the possibility of adding this coverage to such contracts. The answer of BCNWO is to include this coverage in its new high option and low option contracts. (Record p. 122) This will leave those individual subscribers who do not elect one of the new options without this coverage.

(j) Ambulatory Surgical Facilities: This is a new service which can now be rendered by Blue Cross plans in Ohio. BCNWO testified that despite a statewide effort by Blue Cross little interest has been expressed by surgical care providers or employer groups or subscribers. Nevertheless BCNWO has secured approval of a provider contract from the Insurance Department and has one facility interested in this type of contract. BCNWO is also developing a rider that will be available to subscribers to cover surgical procedures in ambulatory free-standing facilities.

I find that BCNWO has made an excellent beginning in the area of alternate forms of care and that it is an area where substantial cost savings can be made. While commending BCNWO on what it has begun I find that it must continue and enlarge its activities in this area and is therefore only in partial compliance with this subsection of the Rule.

Section (F)(7) provides as follows:

"Engagement in and evaluation of cost control experiments, including incentive reimbursement and utilization review programs. Such activities shall include, but need not be limited to experimentation by the Plan and member health care facilities with alternative forms of care, and participation by the Plan and member health care facilities in periodic evaluations of cost control activities."

Without attempting to review all of the programs already referred to, BCNWO testified at length to its utilization review and incentive reimbursement activities.

Utilization Review Committees are functioning in all hospitals in the BCNWO area. (Record p. 125) Blue Cross Provider/Professional Relations Registered Nurses perform periodic review surveys for Blue Cross and Medicare cases in all hospitals. The nurses make evaluations to determine if the care given the patients was appropriate and necessary by reviewing a sampling of patient charts and records. Written reports are furnished to the administrator of the facility and the utilization review committee

chairman. (Record p.p. 125-127) Discussions are going on concerning a combined Blue Cross/Blue Shield utilization review survey. (Record p.p. 121-129) In house Blue Cross utilization nurses are reviewing claims that have not passed medical parameters developed from PAS statistics for the region. (Record p.p. 129-130) It was estimated that the vigorous in house utilization review saved $340,000.00 on Blue Cross bills in 1977. (Record p. 130)

The use of Blue Cross Association statistics permits a comparison of BCNWO results with those of the state and the nation. (Record p. 131) These showed: Admission per thousand subscribers, BCNWO down 3.7%, national Blue Cross down 1.7%; (Record p. 132); inpatient days per 1,000 subscribers (combines admission rates and length of stay) BCNWO down 6.1%, national average down 1.98%, state down 3.8% (Record p.p. 134-135); outpatient visits per 1,000 subscribers, (indicates the extent to which BCNWO has promoted the development and use of alternative health care delivery systems) in 1976 BCNWO 329 outpatient visits per 1,000 subscribers, this was 22.3% more than the national average and 16.3% more than the state average. (Record p.p. 135-136)

With regard to incentive reimbursement BCNWO testified that its provider contracts all contain built in incentives to stay below the limitations and disincentives upon a violation of the ceilings in the contracts. (Record p. 136) In addition BCNWO staff has carefully evaluated the major national pilot programs using incentive reimbursement methods and has found that only a few show promise of controlling costs through the sharing of savings in a cost effective effort with the facility. Its study has permitted BCNWO to extract the best ideas from other incentive programs and use them as a nucleus to develop its own enhanced incentive reimbursement program. (Record p.p. 136-137) (One such pilot program will be implemented January 1, 1978 with Defiance hospital. (Record p.p. 137-139)

BCNWO has been a leader in implementing uniform billing that can be used in all hospitals. Through meetings and seminars support for the concept now includes all Ohio Blue Cross plans and several hospitals. District seminars will be held in late 1977 and in 1978 to assist hospitals in making the transition. Based on savings experienced in California it is estimated that widespread use could save up to $400,000.00 annually in Northwest Ohio. (Record p.p. 139-141)

BCNWO estimated that through its efforts to contain health care costs through its reimbursement system, alternate health care programs and other cost containment activities a total of $9,660,000.00 was saved. (Record p. 144)

Counsel for the Insurance Department throughout his entire cross-examination carefully and thoroughly inquired into every hospital or health care facility program, procedure or expenditure to determine if BCNWO had used education, persuasion and financial incentives and disincentives or a combination of them to control costs and to encourage the hospitals and other health care facilities to control costs. The answers to his questions always involved persuasion usually coupled with education or a financial incentive or disincentive. The financial incentives and disincentives were usually the willingness or unwillingness of BCNWO to reimburse the hospital or health care facility for all or a part of the expenditure of the hospital or facility. This persistent line of inquiry by the Insurance Department served to emphasize the importance of and statutory requirement for seeking out cost control possibilities in every hospital and other health care facility function.

I find that BCNWO has made a good faith effort in this area of its activities and is in compliance with this section of the Rule.

Section (G) provides as follows:

> "The Superintendent shall approve only those contracts, amendments, formulas or rates that are not inconsistent with the cost containment objectives enumerated in Section (F) of this Rule."

This subsection of the Rule relates to the second of the two determinations the Superintendent of Insurance must make relating to the request for his approval of the rate increase proposed by BCNWO. The first of these determinations is whether BCNWO has demonstrated an actuarial need for the proposed increase. I will deal first with this problem and then with whether BCNWO has met its cost containment obligations.

Finding of Fact

Re: Actuarial Need for the Increase

From the evidence adduced at this hearing BCNWO has established:

1) Its non-group experience has sustained a substantial loss every year from 1971 through 1976 and from January 1 through July 31, 1977 totaling $15,748,736. Its loss for the first seven months of 1977 being $2,127,925.

2) Competent actuarial testimony demonstrated the need for at least the rate increase for which approval is asked.

3) Even if the proposed increase is granted in full this block of business would still not be self supporting since its contributions to reserves would still be subsidized by its group business.

4) A rate increase that does not permit some improvement in the reserve position of BCNWO may jeopardize its accreditation by the Blue Cross Association.

Finding of Fact

Re: Cost Containment Activities

Again from the evidence presented at this hearing I find that:

(1) BCNWO has demonstrated a "good faith effort" to control costs, including both its own administrative costs and costs charged to it by health care facilities, including hospitals in connection with most of the sections and subsections of the Rule. However in the most important area of consolidation, sharing, converting or phasing out inappropriate or unnecessary services or facilities; educational programs designed to encourage *subscriber* support of cost containment efforts; and the promotion of alternate forms of care, I find that BCNWO has made a good beginning but is in only partial compliance with the mandate of the law and the Rule. The consolidation or phasing out of unnecessary services or facilities and the promotion of alternate, less expensive, forms of care are two of the areas which can be most productive of real cost savings and a vigorous unrelenting effort in both areas must be carried on. I find that partial compliance does not meet the "good faith effort" mandated by the law.

Recommendation

In view of the evidence presented at the hearing and the findings of fact made from that evidence I conclude that my recommendation must carefully balance the undisputed actuarial need for the full rate increase for which approval is requested against the substantial but still only partial cost containment efforts of BCNWO. I therefore

recommend that the 35.9% rate increase requested be reduced to 25%.

Respectfully submitted,

/s/ W. Lee Shield
W. Lee Shield
Hearing Officer

This 23rd day of December, 1977.

CERTIFICATE OF SERVICE

I hereby certify that a copy of the above Report and Recommendation was submitted to Superintendent of Insurance Harry V. Jump on December 23, 1977. I also certify that copies were sent by regular U.S. mail, postage prepaid, to Mr. Dennis McClung, President, Blue Cross of Northwest Ohio, P. O. Box 943, Toledo, Ohio 43656 and to Mr. James P. Kennedy, Esq., Vorys, Sater, Seymour and Pease, 52 East Gay Street, Columbus, Ohio 43215.

/s/ James F. Mosier
James F. Mosier
Assistant Director
Ohio Department of Insurance

Dated: December 23, 1977.

§ 1739.01 Definitions.

In sections 1739.01 to 1739.20 of the Revised Code:

(A) "Hospital service association" means any corporation organized not for profit under sections 1702.01 to 1702.58 of the Revised Code, for the purpose of establishing, maintaining, and operating a hospital or skilled nursing facility or home health agency service plan, physical therapy service plan, community mental health service plan, ambulatory health facility service plan, or prescription drug service plan by which hospital care may be provided by a hospital, or by a group of such hospitals, or skilled nursing service may be provided by a skilled nursing facility, or by a group of such facilities, or home health service may be provided by a skilled nursing facility, home health agency, or by a group of such agencies, or physical therapy service may be provided by a licensed physical therapist, or by a group of such licensed therapists, or prescription drug service may be provided by a licensed pharmacy, or by a group of such pharmacies, or a community mental health service as provided by a community mental health and retardation board, or mental health service facility, or an ambulatory health service as provided by an ambulatory health facility, or a group of such facilities, with which such corporation has a contract for such purpose to such of the public as become subscribers to said plan under a contract which entitles each subscriber to hospital care, skilled nursing service, or home health service, or physical therapy service, or prescription drug service, or physical therapy service, or prescription drug service, or community mental health service, or ambulatory health service, or any combination thereof.

(B) "Hospital" means any hospital operated in this state which maintains an establishment for the medical, surgical, or psychiatric care of bed patients for a continuous period longer than twenty-four hours, which is open to the general public twenty-four hours each day for emer-

gency care, which has a minimum of ten patient beds, which has an average of two thousand patient days per annum, and which has on duty a registered nurse twenty-four hours each day.

* * *

(E) "Hospital service" or "hospital care" means such service or care as a hospital is legally authorized to render.

* * *

(L) "Lawful, fair and reasonable" contract, amendment, formula, or rate means a contract, amendment, formula, or rate that is in accordance with sound actuarial principles and reflects a good faith effort by a hospital service association to control costs, including both its own administrative costs and costs charged to it by health care facilities, including hospitals.

(M) "Good faith effort" means a conscientious, vigorous, and continuing attempt by a hospital service association through a combination of education, persuasion, and financial incentives and disincentives to control costs and to encourage member health care facilities to control costs by accomplishing the following objectives:

(1) Elimination of duplicative or unnecessary services and facilities;

(2) Nonprovider participation in plan affairs;

(3) Subscriber support of cost containment activities;

(4) Promotion of sound management practices in member health care facilities;

(5) Implementation of sound plan management practices;

(6) Promotion of alternative forms of care;

(7) Engagements in, and evaluation of, cost control experiments, including incentive reimbursement and utilization review programs;

(8) Adoption of other cost containment policies as determined by the superintendent of insurance.

§ 1739.051 [Amendment of contract.]

If any hospital service association desires to:

(A) Enter into or amend any contractual relationship with any hospital, skilled nursing facility, home health agency, community mental health and retardation board, mental health service facility, or ambulatory health facility;

(B) Issue or amend any subscriber contract for such services;

(C) Establish or change any group rating experience formula used in determining a group rate charged for a group subscriber contract;

(D) Establish or change any rate charged for any subscriber contract, other than a group rate for group subscriber contracts determined in accordance with a group rating experience formula which has been approved by the superintendent of insurance. A copy of the proposed contract, amendment, formula, or rate shall be filed with the superintendent of insurance and shall not be effective until the expiration of ninety days after the filing thereof unless he shall sooner give to such association his written approval thereto. If the superintendent is not satisfied within such ninety-day period, that every portion of any such contract, amendment, formula, or rate is lawful, fair, and reasonable, he shall either so notify such association and it shall thereafter be unlawful for such association to use any such contract, amendment, formula, or rate, or that portion or portions of the contract, amendment, formula, or rate which he finds to be unlawful, unfair, or unreasonable, or he shall set a date and time for a public hearing to commence no later than ninety days after receipt of said filing. The superintendent shall give public notice of any such hearing. He may also hold public hearings for hos-

pital service associations to determine compliance with sections 1739.01 to 1739.16 of the Revised Code and rules promulgated thereunder. Such public hearing may include consideration of a proposed contract, amendment, formula, or rate, or may be called by the superintendent with sixty days' written notice to the hospital service association solely to determine the compliance of that association with Chapter 1739. of the Revised Code and rules promulgated thereunder. The superintendent shall develop rules and reporting requirements to indicate activities necessary to establish a good faith effort to control costs. At every public hearing, a hospital service association must show by reliable, probative, and substantial evidence that the association is exerting a good faith effort to control costs. He may also require the association to give public notice of such hearing.

The superintendent may retain at the association's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the superintendent's staff as shall be reasonably necessary to assist in the conduct of any public hearing under this section. Such expenses shall not exceed an amount equal to one one-hundredth of one per cent of the sum of premiums earned plus net realized investment gain or loss of such association as reflected in the most current annual statement on file with the superintendent. Any person retained shall be under the direction and control of the superintendent and shall act in a purely advisory capacity. The superintendent shall, within thirty days after the commencement of a hearing issue an order approving any proposed contract, amendment, formula, or rate if he finds it to be lawful, fair, and reasonable, or approving only that portion of a proposed contract, amendment, formula, or rate which he finds to be lawful, fair, and reasonable, or disapproving any proposed contract, amendment, formula, or rate if he finds it otherwise, or withdrawing his approval of any existing contract,

amendment, formula, rate, or any portion thereof on any of the grounds stated in this section. Any action by the superintendent following a public hearing shall be effected by written order which shall state the grounds for disapproval.

Any action taken or order issued by the superintendent pursuant to this section may be appealed by the association as provided for in section 119.12 of the Revised Code.

RULE 3901-1-28
HOSPITAL SERVICE ASSOCIATIONS

(A) Purpose
(B) Definitions
(C) Reporting Requirements
(D) Reserves
(E) Open Enrollment
(F) Rate Review
(G) Review of Contracts, Amendments, Formulas or Rates
(H) Confidentiality of Records
(I) Severability
(J) Existing Rule Superseded
(K) Effective Date

(A) PURPOSE. Section 1739.051 of the Ohio Revised Code requires the Ohio Superintendent of Insurance to "develop rules and reporting requirements to indicate activities necessary to establish a good faith effort to control costs." The purpose of this Rule is to establish specific requirements which shall be applicable to the operation and regulation of hospital service associations in the State of Ohio.

(B) DEFINITIONS.

(1) "Plan" means a hospital service association licensed under Chapter 1739 of the Ohio Revised Code.

(2) "Contract" means the affiliation agreement entered into by the Plan and the member health care facility.

(3) "Prudent Buyer" means a buyer who seeks to minimize the cost of goods and services consistent with quality and who engages in practices such as competitive bidding

and group purchasing whenever such practices will result in cost savings.

(4) "Good Faith Effort" as used in this Rule shall have the meaning attributed to it in Section 1739.01 (M) of the Ohio Revised Code.

(5) "Member Health Care Facility" means any hospital, skilled nursing facility, home health agency, physical therapy service, community mental health service, ambulatory health facility, prescription drug service, or any other health care facility with which a Plan is authorized to contract pursuant to Chapter 1739 of the Ohio Revised Code and which has entered into an affiliation contract with a Plan.

(6) "Nonprovider" means a member of a Plan's Board of Trustees who is not now, nor has been at any time during the last two (2) years, director, trustee, staff physician or member of an advisory committee of a hospital, skilled nursing facility, home health agency, physical therapy service, community mental health service, ambulatory health facility, prescription drug service, or any other health care facility with which a Plan is authorized to contract pursuant to Chapter 1739 of the Ohio Revised Code.

(C) REPORTING REQUIREMENTS.

(1) In conjunction with any filing for a rate increase or amendment to a rating formula pursuant to Section 1739.-051 of the Ohio Revised Code, a Plan shall provide to the Superintendent a report on its efforts to comply with Sections (F) and (G) of this Rule. This report shall include both a narrative description and appropriate statistical indicators as required by the Superintendent of Insurance.

(2) Every Plan shall make a good faith effort to cooperate with other Plans to develop common procedures and definitions so that the narrative and statistical data pro-

vided under subsection (C)(1) is comparable among the Plans.

(3) Every Plan shall include in its annual report filed pursuant to Section 1739.09 of the Ohio Revised Code an itemized account explaining how its annual dues to the Blue Cross Association have been expended.

(4) Every Plan shall:

(a) Submit to the Superintendent a statement which describes its subscriber grievance mechanism for the expeditious resolution of written complaints initiated by subscribers concerning any matter relating to any provision of the Plan's subscriber contracts including, but not limited to, claims regarding the scope of coverage for health care services and denials, cancellations or nonrenewals of enrollee coverage.

(b) Maintain for examination by the Superintendent a summary record of the complaints filed under the Plan's grievance mechanism and the disposition of each such complaint.

(D) RESERVES

(1) An unassigned surplus of not greater than three (3) months' estimated claims and operating expenses shall be deemed sufficient for all Plans. The Superintendent may give written authorization to a Plan involved in either promoting alternative forms of care or in conducting cost-control activities pursuant to Section (G) to retain additional unassigned surplus.

(2) When for a period of six (6) consecutive months, a Plan's unassigned surplus exceeds the maximum established pursuant to subsection (D)(1), the Plan shall use such funds to effect one or more of the following measures: (a) provide premium credits to appropriate accounts; (b) eliminate the risk factor from appropriate accounts; (c)

provide premium credits to the accounts of all direct pay subscribers; (d) expand benefits to appropriate accounts of all subscribers; and (e) any other appropriate measures to accomplish the same objectives which receive the written approval of the Superintendent.

(E) OPEN ENROLLMENT.

(1) Every Plan shall have an annual open enrollment period of at least thirty (30) days for persons who wish to enroll as direct-pay subscribers. The Plan may impose regulations regarding open enrollment designed to prevent duplicate coverage as well as such underwriting restrictions as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for subscriber coverage of health care services. Such reasonable underwriting restrictions may include health statements, limits on the coverage of pre-existing conditions and probationary periods.

(2) In lieu of an annual enrollment period of at least thirty (30) days, a Plan may have continuous open enrollment for persons who wish to enroll as direct-pay subscribers. The Plan may impose regulations regarding open enrollment designed to prevent duplicate coverage as well as such underwriting restrictions as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for subscriber coverage by health care services. Such reasonable underwriting restrictions may include health statements, limits on the coverage of pre-existing conditions and probationary periods.

(F) RATE REVIEW. Pursuant to Section 1739.01 (L) of the Ohio Revised Code a contract, amendment, formula or rate is lawful, fair and reasonable if it is in accordance with sound actuarial principles and reflects a good faith effort by the Plan to control costs, including both its own admin-

istrative costs and costs charged to it by health care facilities, including hospitals. Pursuant to Section 1739.051 of the Ohio Revised Code, the Superintendent shall not approve a contract, amendment, formula or rate unless the Plan can demonstrate a good faith effort to accomplish the following objectives:

(1) Elimination of duplication or unnecessary services and facilities by:

(a) Refusing to reimburse member health care facilities for any expenses related to a capital expenditure whenever federal reimbursement has been denied for such capital expenditure and consistent with the policy and procedures manual and operating plan of the Ohio Department of Health, the state designated planning agency. This measure shall be effected through the Plan's contract with member health care facilities or by such other means as are approved by the Superintendent.

(b) Making a good faith effort to have member hospitals consolidate, share, convert or phase out inappropriate or unnecessary services or facilities under criteria developed by the appropriate planning agencies, and consistent with the State Plan for Health Facilities of the Ohio Department of Health issued pursuant to Section 3701.39 of the Ohio Revised Code.

(2) Nonprovider participation in Plan affairs by:

(a) Developing and issuing bylaws that clearly and plainly define financial and institutional conflicts regarding a Plan's board of trustees.

(b) Assuring that every Plan committee dealing with relationships with subscribers and health care facilities, including but not limited to its executive committee, rate review committee, and its nominating committee but not including professional advisory committees (e.g., medical advisory committee, hospital advisory committee) be reflective of the non-provider majority on the Plan's Board of Trustees.

(3) Subscriber support of cost containment activities by:

(a) Giving each subscriber timely notification of his right to obtain an itemized bill. Each Plan shall make a good faith effort to see that a subscriber receiving inpatient care is given an itemized bill on his request.

(b) Developing educational programs designed to encourage subscriber support of cost containment efforts.

(4) Promotion of sound management practices in member health care facilities by:

(a) Making a good faith effort to encourage member health care facilities to develop purchasing policies to assure prudent buyer practices.

(b) Making a good faith effort to have member health care facilities establish a bad debt control program as a precondition to Plan reimbursement for the member health care facilities' bad debts. Such a program shall include but need not be limited to, compliance with standard criteria by type of health care facility and patient mix developed by the Plan and containing as a minimum, the following elements: (1) data collection, including age of accounts receivable by the type of payment mechanism; (2) financial counseling; (3) classification of charity patients; and (4) collection procedures.

(c) Making a good faith effort to have member health care facilities establish, maintain and utilize appropriate financial and statistical information systems.

(d) Making a good faith effort to have member health care facilities employ management techniques such as industrial engineering.

(5) Implementation of sound Plan management practices by:

(a) Developing coordination-of-benefits and subrogation policies.

(b) Cooperating with other Plans through the sharing or consolidation of administrative services at an inter-Plan level to improve cost effectiveness and quality of service.

(6) Promotion of alternative forms of care by making a good faith effort to have health care facilities develop alternatives to inpatient care such as outpatient hospital services, ambulatory health facilities as defined in Section 1739.01 (K) of the Ohio Revised Code, home health care services and skilled nursing facility services.

(7) Engagement in and evaluation of cost control experiments, including incentive reimbursement and utilization review programs. Such activities shall include, but need not be limited to experimentation by the Plan and member health care facilities with alternative forms of care, and participation by the Plan and member health care facilities in periodic evaluations of cost control activities.

(G) Review of Contracts, Amendments, Formulas or Rates. The Superintendent shall approve only those contracts, amendments, formulas or rates that are not inconsistent with the cost containment objectives enumerated in Section (F) of this Rule.

(H) Confidentiality of Records. Nothing in this Rule shall be used to interfere with the confidentiality of patient or subscriber records.

(I) Severability. If any section, term, or provision of this Rule be adjudged invalid for any reason, such judgment shall not affect, impair or invalidate any other sec-

tion, term, or provision of this Rule, but the remaining sections, terms and provisions shall be and continue in full force and effect.

(J) Existing Rule Superseded. This Rule rescinds and supersedes existing Ohio Department of Insurance Rule IN-1739-01, on the effective date of this Rule.

(K) Effective Date. This Rule shall become effective on August 19, 1976.